

Betaine (anhydrous for oral solution)

If you have questions, please call 1-888-673-0039

Please fax form to 855-813-2039



PATIENT REFERRAL FORM

*Please print	Last Name:		First Name:		SSN:		Sex: M ☐ F ☐	
	Address:			City:		State:		Zip:
	Phone: Day #		Evening #:		Cell #:		Preferred method of Contact: Day # Evening # Cell #	
	DOB:		Weight Lbs:		Kg:		Height: BSA:	
	If Patient is a Minor, Guardian/Parent Name:				Relation to Patient:			
	Emergency Contact:				Phone #:			
Insurance Information	Primary Insurance Co. Name:						Phone #:	
	Policy Holder Name:			Policy #:			Group #:	
	Prescription Card Name:						Phone #:	
	Policy #:						Group #:	
	Secondary Insurance Co. Name:						Phone #:	
	Policy Holder Name:			Policy #:			Group #:	
Physician Information	Prescriber Name/Title:							
	NPI:		DEA:		Medicaid UPIN:		State License #:	
	Address:			City:		State:		Zip:
	Practice Name:							
	Name of Contact Person:						Phone:	
	Physician Email:						Fax:	
Prescription	Betaine (anhydrous for oral solution) powder:				Mix ____ scoops, note 1 scoop equals 1gram, with 4 to 6			
	Take ____ grams per day; to be divided in ____ doses per day.				Dispense: 30 day supply		ounces of water, juice, milk or formula until completely dissolved or mix with food and take immediately.	
	Refills _____							
	Special Instruction: _____							
Medical Necessity	Please check applicable ICD-10 code:							
	Homocystinuria (E72.11)		Other _____					
	NKDA		Allergies: _____					
I certify I am prescribing Betaine for this patient for a medically necessary purpose.								
Date Written: _____								
Substitution Allowed: _____								
Dispense as Written: _____ (Stamped Signatures Are Not Valid)								
(Stamped Signatures Are Not Valid)								
This Prescription Form is only valid if FAXED to Anovo @855-813-2039								
Form BetaineRx.01 Effective Date: 10/1/25 1341-v3								