Betaine (anhydrous for oral solution)

If you have questions, please call 1-888-673-0039 or email etoncares@optimecare.com Please fax form to 1-866-318-2990

eTon CARES

PATIENT REFERRAL FORM

Patient Information *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:

Take ____ grams per day; to be divided in ____ doses per day.

Dispense:
☐ 30 day supply

Mix ____ scoops, note 1 scoop equals 1gram, with 4 to 6 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: _____

Dispense as Written: _____
(Stamped Signatures Are Not Valid)

Substitution Allowed:
(Stamped Signatures Are Not Valid)_____

This Prescription Form is only valid if FAXED to Optime Care @866-318-2990 or EMAILED to etoncares@optimecare.com

Form: RD-4-01a-ETN
Control: 1341-v2