



PKU GOLIKE WRITTEN ORDER FORM

Phone: 888-639-2110
eFax: 866-869-9442
Email: PKUGOLIKEOrders@pentechealth.com

Referral Date: Clinic Dietitian/Contact: Phone:

Email:

To ensure timely processing, please complete and submit with insurance cards (front & back), LMN signed by prescriber, and recent clinical notes

	Patle	in Detail			
Name:		Sex: 🗆 M 🗆 F		DOB:	
Parent or Legal Guardian, where applicabl	e:				
Address:		City:		State:	Zip Code:
Phone:		Email Address:			
Allergies:		Height:	\Box inches \Box cm	Weight:	□ Ibs □kg
Emergency Contact Name:		Relationship:		Phone:	
	Insura	nce Detail			
\Box Information attached (including front a	and back of insurance car	ds)			
Primary Plan Name:	Subscriber	Subscriber Name:		DOB:	
ID #:	Group #:	Group #:		Phone:	
Secondary Plan Name:	Subscriber	Subscriber Name:		DOB:	
ID #:	Group #:	Group #:		Phone:	
	Presc	riber Detail			
Prescriber Name:	NPI	:		License #:	
Preferred Communication Method: \Box Ph	one 🗆 Fax 🗆 Email				
Address:					
Phone:	Fax:		Email:		
	C	Drder			
 ICD-10 / Diagnosis Description (select): E70.0: Classical phenylketonuria E70.1: Other hyperphenylalaninemia Other: PKU GOLIKE Medical Food - supply as d 					
r no obline medical roou - supply as u	metteu x 1 year				

Product Selection – Select ALL that apply	Units per Day	Units per Month (multiples of 30)
PKU GOLIKE Plus Granules (Ages 4-16; 15g P.E.); 30 x 0.8oz Packets		
□ PKU GOLIKE Plus Granules (Ages ≥16; 20g P.E.); 30 x 1.1oz Packets		
□ PKU GOLIKE Medical Food Bar (Berry, Citrus, Tropical) (10g P.E.); 30 X 2oz Bars		

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Pentec Health may contact this patient for purposes of completing the referral process.

Prescriber Signature:

Date:

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