Pharmacy Phone:_____

Pharmacy Fax:_____

Email:_____

Website:_____

Date: _____

Subject: **Prescription Change Request – Mycophenolate Mofetil Oral Suspension**

Provider: _____ Fax: _____

Patient Name: _____ Date of Birth: _____ is currently prescribed a mycophenolate mofetil 200 mg/mL oral suspension and will be changed to commercially available **Myhibbin® (mycophenolate mofetil oral suspension) 200 mg/mL.**

Key Information about Myhibbin® (mycophenolate mofetil oral suspension):

- FDA-approved
- Ready-to-use oral suspension
- Pack Size: 175 mL
- NDC: 24338-0018-01

For more information visit www.myhibbin.com or scan the QR code for Full Prescribing information, including indications, BOXED WARNING, and additional safety information.

Please update your records and e-prescribe or fax the new prescription to

_____ **Pharmacy at:** _____

CURRENT PRESCRIPTION:
Prescribed Item:
Current SIG:
Last Dispensed:

RECOMMENDATION

Prescribed Item: Myhibbin® (mycophenolate mofetil oral suspension) 200 mg/mL
Updated SIG:
Updated Quantity:
Updated Refills:

Do you have the patient's HIPAA Consent on file authorizing the release of the patient's identification information of Azurity Pharmaceuticals, Inc. and their agents and representational patient assistant services?

Yes No

By signing this form I hereby confirm that I have properly obtained the required consent and authorization (if needed) that are required under Federal HIPAA and other State and Federal privacy laws, to release and share certain protected health information to the Azurity Pharmaceuticals, Inc and any contracted third party. I further certify that the information provided is complete and accurate to the best of my knowledge.

Pharmacist Requesting: _____