CYSTINURIA MANAGEMENT PROGRAM ENROLLMENT FORM
24-HOUR CYSTINE URINE TEST REQUEST

Patient information

LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH GENDER (M/F)

MEDICAL RECORD # (MRN) HEIGHT (inches) WEIGHT (pounds)

STREET ADDRESS

CITY STATE ZIP CODE

HOME PHONE # MOBILE PHONE #

EMAIL

Currently on Thiol-binding medication provided by the Total Care Hub: ☐ YES ☐ NO

If yes, which medication? _____

ALL PATIENT INFORMATION ABOVE MUST BE COMPLETED.

Practitioner information

LAST NAME FIRST NAME

FACILITY NAME

STREET ADDRESS

CITY STATE ZIP CODE

OFFICE/PRACTITIONER PHONE # FAX #

PRACTITIONER NPI # OFFICE CONTACT NAME

PRACTITIONER EMAIL

ALL PRACTITIONER INFORMATION ABOVE MUST BE COMPLETED.

Order

Diagnosis: ☐ E72.01 CYSTINURIA ☐ OTHER _____

Diagnosis in ICD-CM format in effect at date of service (highest specificity required)

24-hour cystine urine panels *(for patients with known cystinuria)*

TESTS		
Cystine concentration	Urine pH	Urine Sodium
Timed collection	Urine volume	Urine Nitrogen
Quantitative cystine	Urine Calcium	Creatinine

ALL TESTS WILL BE PERFORMED ON EACH 24-HOUR URINE COLLECTION.

Testing will be performed by Select Reference Laboratories, LLC.

TEST FREQUENCY INSTRUCTIONS, SEND COLLECTION KIT TO PATIENT EVERY:

☐ 3 MONTHS* ☐ 4 MONTHS* ☐ 6 MONTHS* ☐ 12 MONTHS* ☐ HOLD SHIPMENT OF TEST UNTIL: _____/_____/_____

Prescriber Direction:_____

I request a copy of the 24-hr cystine urine results be mailed directly to this patient. ☐

*In a 12-month period.

For questions regarding this program, contact the Cystinuria Management Program at:

1-855-846-5390, M-F: 8:00AM-8:00 PM (ET)

SUBMIT THIS COMPLETED FORM:
Via Fax: 1-844-889-2577
Via Email: info@ManagingCystinuria.com

All orders will be processed next business day.

Criteria for free testing:

Patient has been diagnosed with cystinuria.

I hereby attest that the patient has been diagnosed with cystinuria and is a candidate for this 24-Hour Cystine UrineTest. I understand that the diagnostic testing services offered under this program are directional in nature and that they do not eliminate the need for additional medical management.

Authorized practitioner signature Date

Program may be cancelled or changed at any time.

TRAVERE THERAPEUTICS