



# Zavesca Prescription Form

1. DOCTOR/PRESCRIBER FILL OUT AND  
FAX TO: 1-866-413-4139 or Call: 1-888-281-5582

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

### Patient Information New Rx Refill

Name: \_\_\_\_\_ Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_  
 Address: \_\_\_\_\_ Allergies: \_\_\_\_\_  No Known Allergies  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Health Conditions: \_\_\_\_\_  
 Date of Birth (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expected Start Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Statement of Medical Necessity

Patient Weight: \_\_\_\_\_  lbs  kg Primary Diagnosis: \_\_\_\_\_ ICD9 Code: \_\_\_\_\_

### Drug Delivery Information

If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

Home Delivery Other: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Contact: \_\_\_\_\_ Address: \_\_\_\_\_

### Insurance Information

Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_  
 Insured: \_\_\_\_\_ Insured: \_\_\_\_\_  
 ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Rx Drug Card #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Rx Drug Card #: \_\_\_\_\_  
 RxBin #: \_\_\_\_\_ RxPCN #: \_\_\_\_\_ Rx Grp #: \_\_\_\_\_ RxBin #: \_\_\_\_\_ RxPCN #: \_\_\_\_\_ Rx Grp #: \_\_\_\_\_

### Doctor/Prescriber Information

NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

2. COMPLETE THE FOLLOWING RX FORM -OR- TAPE RX HERE

Rx		Date: ____ / ____ / ____
Drug Name/Form/Strength	Directions for Use	
Zavesca® (miglustat) capsules 100mg	<input type="checkbox"/> Take 100mg by mouth three times a day <input type="checkbox"/> Other: _____  Quantity: _____ Refills: _____	
X _____	X _____	
Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted	Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted	