Zavesca
(Miglustat)

Prior Authorization Form
Curascript
Fax (888) 773-7386

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address City State ZIP		Address City State ZIP	
VH ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) ☐ Physician ☐ Home		Special Instructions (i.e. Non-English Speaking Patient, etc.):	

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number

1. **Is the diagnosis or indication for the treatment of Gaucher disease, type 1?**
2. **Has the diagnosis been confirmed by laboratory or genetic testing?**
3. **Is the patient intolerant to Enzyme Replacement Therapy (Cerezyme) or has a poor venous access?**
4. **Are there any other comments, diagnoses, symptoms, and/or any other information you feel is important to this review?**

Physician's Signature: ____NPI/DEA #: ____________________ Date: ______________

For Internal Use Only
☐ Approved ☐ Denied Reviewer's Initials _________________ Decision Date __________________
Comments____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.