



Zavesca (Miglustat)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: 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, SCAN 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 mild-to-moderate Gaucher disease, type 1?
2. Has the diagnosis been confirmed by laboratory or genetic testing?
3. Is the Enzyme Replacement Therapy (Cerezyme) not a therapeutic option for a patient due to an allergy, hypersensitivity or 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.