

# ZAVESCA® (miglustat) Prescription Form

accredo®



## 1. DOCTOR/PRESCRIBER: FILL OUT AND FAX TO: 1-877-773-9233 or call: 1-877-472-1326

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

### Patient Information ☐ New Rx ☐ Refill

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Date of Birth (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_  
Allergies: \_\_\_\_\_ ☐ No Known Allergies  
Concurrent Medications: \_\_\_\_\_  
Health Conditions: \_\_\_\_\_  
Expected Start Date (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Statement of Medical Necessity

Patient Weight: \_\_\_\_\_ ☐ lb ☐ kg  
ICD9 Code: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_  
ICD10 Code: \_\_\_\_\_

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

☐ Home Delivery Other: \_\_\_\_\_  
Contact: \_\_\_\_\_

Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

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

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

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

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Office Contact: \_\_\_\_\_  
NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
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 _____ Doctor/Prescriber Signature – Dispense as Written Stamped signature cannot be accepted		X _____ Doctor/Prescriber Signature – Substitution Permissible Stamped signature cannot be accepted

New York prescribers, please submit prescription on an original NY State prescription blank.

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.

**IMPORTANT CONFIDENTIALITY NOTICE:** This and any documents accompanying this transmission may contain confidential health information that is protected under federal and state laws. This information is intended solely for the use of the individual or entity listed on this form. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, or have otherwise received this information in error, please do not read the contents of this form. Please notify the sender immediately and arrange for the return or destruction of this form. If you are not the intended recipient or have otherwise received this information in error, any use, disclosure, copying or, distribution of, or action taken in reliance on, the contents of these documents is strictly prohibited and may be unlawful. If you have additional questions, please contact Actelion Pathways at 1-866-228-3546.