

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Zavesca® (miglustate)

**Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241**

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
<input type="checkbox"/> Zavesca (miglustate)	_____	_____	_____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request

Yes No Patient is 18 years of age or older

Yes No Patient has the diagnosis of Type I Gaucher disease

The presence of type 1 Gaucher Disease is confirmed by either of the following:

Yes No Glucocerebrosidase activity in the white blood cells or skin fibroblasts less than or equal to 30% of normal activity

Yes No Genotype testing indicates mutation of two alleles of the glucocerebrosidase genome

Yes No Patient has clinically significant manifestations of Gaucher disease which includes either of the following:

Yes No Patient presents with **at least two** of the following:

Yes No Clinically significant hepatomegaly

Yes No Clinically significant splenomegaly

Yes No Platelet count less than or equal to 120,000mm³

Yes No Hemoglobin less than or equal to 11.5 g/dL for females and less than 1 2.5 g/dL for males, or 1.0g/dL below lower limit for normal for age and sex

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Patient Name: _____ **Patient ID #:** _____

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skeletal disease as demonstrated by any of the following:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Avascular necrosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Erlenmeyer flask deformity (failure of bone remodeling)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lytic disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Marrow infiltration
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteopenia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteosclerosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pathological fracture
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiological evidence of a joint deterioration
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Enzyme replacement therapy with alglucerase (Ceredase) or imiglucerase (Cerezyme) is contraindicated due to intolerability, allergy to components of these drugs, or poor venous access
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the patient pregnant or considering becoming pregnant?

9. PHYSICIAN SIGNATURE

_____	_____
Prescriber or Authorized Signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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