



# Prior Authorization Request

Date of Request \_\_\_\_\_

<b><u>Zavesca</u></b>	<b>Zavesca (Miglustat) is used to treat Gaucher Disease. It has limited distribution.</b>
	Patient diagnosed with type I (non-neuropathic) Gaucher Disease with anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.
	Patient tested for IgG antibodies to alglucerase or miglustat. Note that the presence of antibodies is associated with an increased risk of hypersensitivity reactions.
	[12 months]

Enrollment / Cardholder ID _____	<b>Gender</b> (Circle)
Group / Plan _____	Male      Female
Birth date _____	AGE: _____ Weight (kg): _____
Address: _____	
City State Zip _____	

### Practitioner Information

Name \_\_\_\_\_

Agent / Contact Name \_\_\_\_\_

Specialty \_\_\_\_\_

Office / Clinic Name \_\_\_\_\_

Address \_\_\_\_\_

City State Zip \_\_\_\_\_

Phone (    ) - \_\_\_\_\_

Fax (    ) - \_\_\_\_\_

ID Number \_\_\_\_\_

Email \_\_\_\_\_ @ \_\_\_\_\_

<b>IgG Antibodies?</b>	<b>Y</b>	<b>N</b>
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### Requested Drug / Pharmaceutical

<b>Zavesca (Miglustat)</b>
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<b>Strength / Dose</b>
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### Condition / Diagnosis Related - Reason for Request

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<b>Therapy Start Date</b>
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<b>Duration of Therapy</b> (Expected)
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### Clinical Drug / Lab History Pertinent to Request

<u>Labs:</u>	<u>Baseline / Ongoing</u>
Formulary Alternative(s) Attempted	YES      NO (Circle)
Please List:	

<b>Type of Request</b> (Circle)
<b>One-Time    On-Going</b>

<b>Contact Pharmacy?</b> Y    N
Pharmacy Phone Number

\_\_\_\_\_  
**Practitioner Signature**

Date Received:  
Reviewed By:  
Forwarded To:

**FAX Form to:**  
**877-800-5633**

**HT Clinical Services Phone**  
**866-805-1690**