Zavesca® (miglustat)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: ______________________________
Pharmacy Phone: ______________________________

STEP 2

Complete the Clinical Assessment:

Diagnosis	☐ Adult type 1 Gaucher disease (mild to moderate severity)	☐ Other (please state):
Clinical Consideration	☐ Patient tried and failed enzyme replacement therapy	
	☐ Patient is not a candidate for enzyme replacement therapy	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Zavesca® (miglustat) Strength ______________________________ Sig ______________________________ Qty ______________________________ Refills ______________________________	
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

______________________________ Prescriber Signature

______________________________ Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: ______________________________

Pharmacy Technician initials ______ Date Initiated ____________________

Confidentiality Notice:

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