

## Sterling Retiree Rx Prior Authorization Form

### ZAVESCA (Miglustat)

**Coverage Criteria / Required Medical Information**

**Patient must be at least 18 years of age.**

- A. Diagnosis of Gaucher Disease confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity < 30%.
- B. Trial and failure of enzyme replacement therapy or is not a therapeutic option.
- C. Female patients of childbearing age will be on a form of contraception or have no ability to conceive and been educated on the potential dangers of Zavesca therapy.

**Reauthorization Criteria**

Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who have previously received 24 months of Zavesca therapy.

**Exclusion Criteria:**

renal failure; pregnancy; labor/obstetric delivery.

#### Member Information

<b>Name</b>					
<b>Enrollment/Card-holder ID Number</b>					
<b>Group/Plan</b>		<b>Male</b>		<b>Female</b>	
<b>Date of Birth</b>		<b>Age</b>		<b>Weight in Kg</b>	
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	

#### Physicians Information

<b>Name</b>					
<b>Agent</b>		<b>Contact Name</b>			
<b>Specialty/Office</b>					
<b>Clinic Name</b>					
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Phone</b>		<b>Fax</b>			



**Sterling Retiree Rx Prior Authorization Form**

Requested Drug			
ZAVESCA	Reason for Request		
Condition/Diagnosis Related			
Clinical Drug/Lab History Pertinent to Request			
Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?		Yes:	No:
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: \_\_\_\_\_

Fax Form to 1-866-481-3704