PROGRAM PHONE: **833-582-3538** FAX: **866-854-0860**

YARGESA PATIENT ENROLLMENT

1 PATIENT INFORMATION

(Please complete the following information)

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: ☐ Male ☐ Female Phone Number: _____ ☐ Home ☐ Mobile Email Address: _____

Caregiver Name (First, Last): _____ Relationship to Patient: _____ Caregiver Phone Number: _____

Does Patient have Insurance? ☐ Yes (Complete Section 2 Below) ☐ No (Skip to Section 3)

2 INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card, prescription card,and/or Medicaid card.**

Primary Insurance Name: _____

Primary Insurance ID: _____

Insurance Group Number: _____

Insurance Phone Number: _____

Policyholder Name: _____

Secondary Insurance Name: _____

Secondary Insurance ID: _____

Insurance Group Number: _____

Insurance Phone Number: _____

Policyholder Name: _____

Prescription Insurance Name: _____ Policy Holder ID: _____

Rx BIN: _____ Rx PCN: _____ Rx Group: _____

Policy Holder Name: _____ Relationship to Patient: _____

3 CLINICAL INFORMATION

☐ **Please fax clinical documentation to pharmacy along with referral form.**

Has the Patient previously been on miglustat? ☐ Yes ☐ No Therapy Start Date: _____

Primary ICD-10 Code: _____ Secondary ICD-10 Code: _____

☐ NKDA ☐ Drug Allergies: _____

Patient Weight: _____ ☐ lbs ☐ kg Date of Weight Measured: _____ Patient Height: _____ ft _____ in

Concurrent Medications or Attach Medication List: _____

_____

Previous Therapies: _____

Does the Patient have renal impairment? ☐ Yes ☐ No CrCl: _____ mL/min Date Measured: _____ BSA: _____ m^2

4 PRESCRIBER INFORMATION

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Office Address: _____ City: _____ State: _____ Zip: _____

Office Contact Name: _____ Email Address: _____ : _____ : _____

Office Phone: _____ Office Fax: _____

5 PRESCRIPTION INFORMATION

YARGESA (miglustat) 100 mg capsules

☐ **Prescriber authorizes Quick Start if insurance delays. (10 day supply with 2 refills)**

Patient's First Name: _____ Last Name: _____ Date of Birth: _____

Directions: _____ Qty: _____ Refill: _____

Prescriber Signature (Sign either line A or B below.) (Physician attests this is his/her legal signature. **NO STAMPS**)

_____ _____ _____ _____

A. DISPENSE AS WRITTEN* **DATE** **B. PRODUCT SUBSTITUTION PERMITTED** **DATE**

*Certain states require "brand medically necessary" or other language to be handwritten by the prescriber if he/she has made this determination in his/her independent clinical judgment.

Notes: The prescriber should comply with state-specific prescription requirements. Noncompliance could result in outreach to the prescriber.

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