

Prescription & Enrollment Form Gaucher Disease

(800) 962-6339 Office
(866) 755-6339 Fax



Patient Information

_____	_____
Last Name	First Name
_____	_____
Social Security #	Date of Birth
_____	_____
Parent or Guardian	
_____	_____
Home Phone	Other Contact Phone
_____	_____
Home Address	

City, State, Zip	

Insured Information

Primary Insurance (Fax copy of card – both sides)	

Subscribers Name	Relationship to Patient
_____	_____
Policy #	Group #
_____	_____
Primary Insurance Phone	

Prescription Card (Fax copy of card – both sides)	

Carrier	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses)			
<input type="checkbox"/> 272.7 Lipidoses (Gaucher Disease)		<input type="checkbox"/> Other ICD 9	
Lab Values: Hemoglobin/HCT	Platelet Count	Acid Phosphatase	AT/ALT
Is patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Diagnosis	Allergies:

PRESCRIPTION INFORMATION				
Medication	Dose	Frequency	Quantity	Refills
<input type="checkbox"/> Cerezyme ® (Imiglucerase)				

DELIVERY INSTRUCTIONS		
<input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other	Address _____ City/State/Zip _____	Date Medication Needed

Physician's Name (Please Print)	Physician's DEA#
Physician's Address	Physician's Signature
Phone	Date
Fax	
License #	Dr.'s Office Contact Name
NPI #	Contact Phone #

Fax completed form to Medex BioCare (866) 755-6339