

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ZAVESCA (miglustat)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Minimum age: 18 years old
- Diagnosis: moderate type 1 Gauchers disease
- Documentation that enzyme replacement has failed.
- Documentation that hemoglobin is >9g/dL
- Platelet count >50k/ul. **(FAX COPY OF LAB WORK)**
- Written consultation with trained specialists (either a geneticist or hemotologist)

INFORMATION:

Cumulative limit: 90 capsules/30 days

Dosage: 100mg t.i.d. recommended. May be decreased to once or twice a day based on side effects.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

9/21/10

<https://medicaid.utah.gov/pharmacy/>