meijer specialty pharmacy

P: 1-855-263-4537 • F: 734-391-2365
www.meijerspecialtypharmacy.com

◯ New/Changed Dose

Wilson's Disease

Clovique™, Cuprimine®, Galzin®, Syprine®

Prescriber Information

Prescriber Name:	◯ MD ◯ DO ◯ NP ◯ PA	NPI:	
Office Contact:	Practice Name / Collaborating MD:		
Address:	City:	State:	Zip:
Phone:	Fax:		

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patients Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic? ◯ Y ◯ N
Office Contact:	Practice Name / Collaborating MD:					
Address:	City:	State:	Zip:			
Home Phone:	Work/Cell:	HIPAA Contact:	Emergency #:			
Interpreter Needed? ◯ Y ◯ N	Allergies: ◯ Y ◯ N **If Yes, list allergies:**					

Insurance Information

Primary Insurance:	Policy ID:	Group #:	BIN:	PCN:
Policyholder Name:	Policyholder DOB: / /			

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	◯ Wilson's Disease (E83.01) ◯ Other:	
Prior Treatment? ◯ Y ◯ N **(Provide Information Below)**	Approx. Start Date: / /	Approx. End Date: / /
Prior Therapy:	Reason for Discontinuation of Therapy:	
Comorbidities:	Concomitant Medications:	Allergies: ◯ NKDA ◯ Other:

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **CLOVIQUE™** (trientine HCl)	◯ 250mg capsule (30 Day Supply)	◯ Take _____mg by mouth _____ times a day ◯ Other:	
◯ **CUPRIMINE®** (penicillamine)	◯ 250mg capsule (30 Day Supply)	◯ Take 250 mg by mouth 4 times a day ◯ Other:	
◯ **GALZIN®** (zinc acetate)	◯ 50mg capsule (30 Day Supply)	◯ Take 50 mg by mouth 3 times a day ◯ Other:	
◯ **SYPRINE®** (trientine HCl)	◯ 250mg capsule (30 Day Supply)	◯ Take _____mg by mouth _____ times a day ◯ Other:	

Injection Training

◯ Patient received injection training	◯ Prescriber's office to provide injection training	◯ Meijer to coordinate injection training

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature	Date	Prescriber Signature	Date

Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.