meijer specialty pharmacy

**P: 1-855-263-4537 • F: 1-866-922-3220**
**www.meijerspecialtypharmacy.com**

# 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: | HIPPA 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<br>○ Other: | |
| ○ **CUPRIMINE®** (penicillamine) | ○ 250mg capsule (30 Day Supply) | ○ Take 250 mg by mouth 4 times a day<br>○ Other: | |
| ○ **GALZIN®** (zinc acetate) | ○ 50mg capsule (30 Day Supply) | ○ Take 50 mg by mouth 3 times a day<br>○ Other: | |
| ○ **SYPRINE®** (trientine HCl) | ○ 250mg capsule (30 Day Supply) | ○ Take _____mg by mouth _____ times a day<br>○ 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.**

MSP-Wilsons-NE-030122