

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 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
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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
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Substitution Permitted

Dispense as Written

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