



Fabrazyme® (agalsidase beta) Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND
FAX TO: 1-866-413-4139 or Call: 1-866-413-4138

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information New Rx Refill

Name: _____ Phone #1: _____ Phone #2: _____
 Address: _____ Allergies: _____ No Known Allergies
 City: _____ ST: _____ Zip: _____ Health Conditions: _____
 Date of Birth (mm/dd/yyyy): ____/____/____ Expected Start Date: ____/____/____

Statement of Medical Necessity

Patient Weight: _____ lbs kg Primary Diagnosis: _____ ICD9 Code: _____

Drug Delivery Information

If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

In Office Delivery Home Delivery for Self Injection/Administration Contact: _____
 Home Delivery for Home Health Administration Phone #: _____
 Other: _____ Address: _____

Insurance Information

Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: _____ Secondary: _____
 Insured: _____ Insured: _____
 ID #: _____ Group #: _____ ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____ Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____ Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Doctor/Prescriber Information

NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: _____ Office Contact: _____
 Address: _____ NPI #: _____ DEA #: _____
 City: _____ ST: _____ Zip: _____ Phone #: _____ Fax #: _____

2. COMPLETE THE FOLLOWING Rx FORM -OR- TAPE Rx HERE

Rx		Date: ____/____/____
Drug Name/Form/Strength	Directions for Use	
<input type="checkbox"/> Fabrazyme®		
Sodium Chloride 0.9% <input type="checkbox"/> 50 mL Bag <input type="checkbox"/> 100 mL Bag <input type="checkbox"/> 250 mL Bag <input type="checkbox"/> 500 mL Bag		
Other:		
Quantity: _____ Refills: _____		
Needles Gauge: _____ Inches: ____ Quantity: ____ Refills: ____	Syringes Volume: _____ Inches: ____ Quantity: ____ Refills: ____	
X _____ Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted	X _____ Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted	

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.
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