



Myozyme® (alglucosidase alfa) 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: _____
 Patient has compromised cardiac or respiratory function Patient will be monitored for serious acute exacerbation due to infusion reactions

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

Date: ____/____/____	
Drug Name/Form/Strength	Directions for Use
<input type="checkbox"/> Myozyme® 50mg vials <input type="checkbox"/> Sodium Chloride 0.9% Bag <input type="checkbox"/> 50 mL <input type="checkbox"/> 100 mL <input type="checkbox"/> 150 mL <input type="checkbox"/> 200 mL <input type="checkbox"/> 250 mL <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Sterile Water for Injection, 10cc vial, preservative free <input type="checkbox"/> Sharps Container <input type="checkbox"/> Alcohol Pads 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