

Please select one: **Newly prescribed patient** **Already on Galzin®**

Patient Information <i>Please Print</i>	Last Name:		First Name:		SSN:		Sex: M F						
	Address:			City:		State:		Zip:					
	Phone Day #:		Evening #:		Cell #:		Preferred method of contact: Day Evening Cell						
	Email:			DOB:	Weight Lbs:	Kg:	Height:	BSA:					
	If Patient is a Minor, Guardian/Parent Name:					Relationship to Patient:							
	Emergency Contact:				Phone #:								
Insurance Information	Primary Insurance Co. Name:						Phone #:						
	Policy Holder Name:				Policy #:		Group #:						
	Prescription Card Name:						Phone #:						
	Policy #:						Group #:						
	Secondary Insurance Co. Name:						Phone #:						
	Policy Holder Name:				Policy #:		Group #:						
Physician Information	Prescriber Name/Title:					Phone #:							
	NPI:		DEA:		Medicaid UPIN:		State License #:						
	Address:			City:		State:		Zip:					
	Name of Office Contact Person:				Office Contact Person Email:								
	Office Contact Person Phone:				Office Contact Person Fax:								
	PA Office Contact Name:				PA Office Contact Name:								
Prescription	Galzin® (zinc acetate) capsules: 25mg 50mg Custom Dosing Instructions: Galzin 25mg: Take ____ capsule(s) on an empty stomach ____ times per day. _____ QTY: ____ (30 day supply) Refills: ____ QTY: ____ (90 day supply) Refills: ____ _____ Galzin 50mg: Take ____ capsule(s) on an empty stomach ____ times per day. _____ QTY: ____ (30 day supply) Refills: ____ QTY: ____ (90 day supply) Refills: ____ _____												
Medical Necessity	Please check applicable: _____ Therapy Start Date: _____ Disorder of copper metabolism, unspecified (E8300) Other disorders of copper metabolism (E8309) Wilson's disease (E8301) Other: _____												
Clinical Background	Allergies: _____ NKDA												
	Concurrent and Previously Prescribed, if any (optional) <table border="0"> <tr> <td>Galzin (zinc acetate Rx)</td> <td>Gluzin (zinc gluconate supplement)</td> <td>Trientine (chelator)</td> </tr> <tr> <td>Penicillamine (chelator)</td> <td>Other zinc therapy</td> <td>None</td> </tr> </table>								Galzin (zinc acetate Rx)	Gluzin (zinc gluconate supplement)	Trientine (chelator)	Penicillamine (chelator)	Other zinc therapy
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Penicillamine (chelator)	Other zinc therapy	None											

NY Prescribers—Please submit the prescription on an original NY State prescription blank.

I certify I am prescribing Galzin® for this patient for a medically necessary purpose. Date Written: _____

Dispense as written: _____

(Stamped Signatures Are Not Valid)

Substitution allowed: _____

(Stamped Signatures Are Not Valid)