Galzin®
(zinc acetate) capsules

Patient Referral Form

Phone: 833-4-GALZIN (833-442-5946)
etoncares@optimecare.com

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

Patient Information *Please Print*

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: ____

Galzin 50mg: Take ____ capsule(s) on an empty stomach ____ times per day.

QTY: ____ (30 day supply) Refills: ____

Medical Necessity

Please check applicable: Therapy Start Date: _____

- ☐ **Disorder of copper metabolism, unspecified (E8300)**
- ☐ **Wilson's disease (E8301)**
- ☐ **Other disorders of copper metabolism (E8309)**
- ☐ **Other:** _____

Allergies: ☐ NKDA

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)*

This Prescription Form is only valid if FAXED to Optime Care @ 866-318-2990 or EMAILED to etoncares@optimecare.com.

Part Number: 1792-v1
Form: RD-4-01h-ETN