Galzin®
(zinc acetate) capsules

Patient Referral Form

Phone: 833-4-GALZIN (833-442-5946)
Fax: 855-813-2039

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: ____ 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)*

☐ **Galzin (zinc acetate Rx)**
☐ **Gluzin (zinc gluconate supplement)**
☐ **Trientine (chelator)**
☐ **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)*

eTon CARES

This Prescription Form is only valid if FAXED to Anovo @ 855-813-2039

Form: GalzinRx.01
Effective date: 10/1/25
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