AcariaHealth
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

NOXAFIL REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) _____

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

  _____
- Noxafil is contraindicated with the following: Sirolimus, ergot alkaloids and CYP3A4 substrates: terfenadine, astemizole, cisapride, pimozide, halofantine and quinidine; HMG-CoA Reductase inhibitors (statins) metabolized through CYP3A4.

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

❑**Noxafil 40 mg/mL oral suspension**
- ❑100 mg (2.5 mL) PO BID on the first day, then 100 mg (2.5mL) daily for 13 days — QTY: ____ Refills:____
- ❑400 mg (10mL) PO BID — QTY: ____ Refills:____
- ❑200 mg (5mL) PO TID — QTY: ____ Refills:____

❑**Noxafil 300 mg/16.7 mL intravenous solution**
- ❑300 mg (16.7 mL) IV BID on the first day, then 300 mg (16.7 mL daily) — QTY: ____ Refills:____

❑**Noxafil 300 mg delayed release tablets**
- ❑300 mg (3 of 100 mg tablets) BID on the first day, then 300 mg (3 of the 100 mg tablets) daily — QTY: ____ Refills:____

❑**Other:** _____ QTY: ____ Refills:____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

3.15.19