

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: <input type="checkbox"/> M <input type="checkbox"/> F	Weight:	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> 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 ASSESSMENT

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

<input type="checkbox"/> Noxafil 40 mg/mL oral suspension		
<input type="checkbox"/> 100 mg (2.5 mL) PO BID on the first day, then 100 mg (2.5mL) daily for 13 days	QTY: _____	Refills: _____
<input type="checkbox"/> 400 mg (10mL) PO BID	QTY: _____	Refills: _____
<input type="checkbox"/> 200 mg (5mL) PO TID	QTY: _____	Refills: _____
<input type="checkbox"/> Noxafil 300 mg/16.7 mL intravenous solution		
<input type="checkbox"/> 300 mg (16.7 mL) IV BID on the first day, then 300 mg (16.7 mL daily)	QTY: _____	Refills: _____
<input type="checkbox"/> Noxafil 300 mg delayed release tablets		
<input type="checkbox"/> 300 mg (3 of 100 mg tablets) BID on the first day, then 300 mg (3 of the 100 mg tablets) daily	QTY: _____	Refills: _____
<input type="checkbox"/> 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 the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document.