Physician Request Form Ixempra®

Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

AmeriHealth Caritas District of Columbia

Patient Name: _____ Patient ID#: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #:_____ Height: _____ Weight: _____lbs = _____Kg Birth Date: _____

Physician Name: _____ License #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____Phone #: _____ Fax #: _____

Physician Signature: _____ Date: _____

Diagnosis: _____ ICD-9 Diagnosis Code: _____

⑨ **Deliver to Patient's Home** ⑨ **Deliver to Physician's Office** ⑨ **Pick-up at Local Pharmacy (Name/Phone #)**_____

To be Administered From: _____ to _____ OR on: _____Date of Request**:**_____

Sig (dosage and how Ixempra® will be administered): _____

⑨ **Naive Therapy** ⑨ **Continuation of Therapy**

Is the patient on concurrent Xeloda® (capecitabine) therapy? (please check) ⑨ Yes ⑨ No If yes, indicate the dose of Xeloda®: _____

Labs **(Please submit a copy of the <u>most recent</u> labs and/or complete the following - lab values should be within 30 days of request)**

AST: _____ normal range _____ ALT: _____ normal range _____ Date of labs: _____

Bilirubin _____ normal range _____ Date of lab: _____

Neutrophil Count: _____ cells/mm^3 Date of Lab: _____

Platelet Count: _____cells/mm^3 Date of Lab: _____

Previous therapies used to manage patient's condition: (please include treatment regimens with the names of the medication, doses, duration of therapy and reason for stopping therapy):

_____

_____

_____

_____

Diagnosis other than advanced and/or metastatic Breast Cancer

- Rationale for choosing this treatment, please include all applicable documentation:

_____

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