

Physician Request Form Ixempra®

Fax to PerformRx Pharmacy Services at **888-981-5202**, or to speak to a representative call **866-610-2774**. *Form must be completed for processing.*

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: _____

Deliver to Patient's Home Deliver to Physician's Office 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): _____

Naive Therapy Continuation of Therapy

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

Labs (Please submit a copy of the most recent 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/mm³ Date of Lab: _____

Platelet Count: _____ cells/mm³ 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

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