Impavido® (miltefosine) capsules Patient Referral Form

Fax: 855-813-2039
Phone: 877-469-4078

anovo SPECIALTY PHARMACY

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 # ☐
DOB:	Weight Lbs:	Kg:	
If Patient is a Minor, Guardian/Parent Name:		Relation 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 Phone:	

Prescription

Impavido (miltefosine) 50mg capsule

Quantity to dispense: ____ day supply

☐ **30 to 44 kg:** Take (1) 50 mg capsule by mouth twice daily with food.

☐ **45kg or greater:** Take (1) 50 mg capsule by mouth three times a day with food.

Special Instructions:

Medical Necessity

Please check applicable ICD-10 Code:

Therapy start Date: _____

☐ Other ICD-10 Code: _____ Description: _____

☐ Visceral leishmaniasis (B55.0)

☐ Mucocutaneous leishmaniasis (B55.2)

☐ Cutaneous leishmaniasis (B55.1)

☐ Leishmaniasis, unspecified (B55.9)

Allergies: ☐ NKDA

A urine pregnancy test was performed and read as negative prior to prescribing Impavido. The patient has been counseled on the embryo-fetal toxicity risk of Impavido, the need for effective contraception during treatment and for 5 months after the last dose, and has agreed to these requirements.

I certify I am prescribing Impavido for this patient for a medically necessary purpose. **Date Written:** _____

Dispense as Written: _____ **Substitution Allowed:** _____

(Stamped Signatures Are Not Valid) (Stamped Signatures Are Not Valid)

Form: Impavido.Rx.01
Effective Date: 09.20.26
2662-v1

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