

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				Special Instructions:				
	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.				☐ Prescriber acknowledges Impavido is being prescribed off label based on clinical judgment.				
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)									