Physician Prescription Request Form for Hemophilia Drugs
Fax to PerformRx Pharmacy Services at 877-693-8280, or to speak to a representative call 800-578-0898. *Form must be completed for processing.* Urgent fax is 877-693-8476.

Patient Name: ______________________ Plan ID#: ______________________

Address: ______________________ Apt # or Suite #: ______________________

City: ______________________ State: __________ Zip Code: ______________________

Phone #: __________ Height: ________ Weight: ________lbs = ________Kg Birth Date: ______________________

Physician Name: ______________________ NPI #: ______________________

Address: ______________________ Apt # or Suite #: ______________________

City: ______________________ State: __________ Zip Code: ______________________

Contact Person: ______________ Phone #: __________ Fax #: ______________________

Physician Signature: ______________________ Date: ______________________

For **initial therapy** requests please fill out **Part A and B only** and for **renewal therapy request** please fill out **Part B and C**
Attach diagnostic test results with request. Four weeks of therapy will be approved with 1 refill (total 8 weeks of therapy) for initial and reauthorization request. Contact the pharmacy to have refills processed and medications shipped to the office. Allow 2 business days for delivery.

Part A

1. Does the patient have colorectal cancer? **(circle answer)** **Yes** **or** **No**
   If Yes, indicate how this was diagnostically determined (i.e. CT scan, colonoscopy etc) ______________________
2. Does the patient have metastatic colorectal cancer? **(circle answer)** **Yes** **or** **No**
   If Yes, indicate the area of metastasis (liver and/or lung and/or abdominal peritoneal) ______________________
3. If the patient has metastatic cancer, is the cancer resectable? **(circle answer)** **Yes** **or** **No** **or** **N/A**
   If No, provide medical reason for why cancer is not resectable: ______________________
4. If the patient does not have metastatic colorectal cancer, is the colorectal cancer resectable? **(circle answer)** **Yes** **or** **No** **or** **N/A**
   If No, provide medical reason for why cancer is not resectable: ______________________
5. Has the patient had a severe hemorrhage or hemoptysis in the past six months requiring medical intervention? **(circle answer)**: **Yes** **or** **No**
   If yes, explain ______________________
6. Based on clinical assessment indicate the patients performance status: **(circle answer)** **0** **1** **2** **3** **4** **5**
7. Is the member enrolled in a clinical trial? **(circle answer)** **Yes** **or** **No**.

Part B

1. Has the patient received any surgical procedure(s) in the past 28 days? **(circle answer)** **Yes** **or** **No**
   If yes, please explain: (attach copy of description of the procedure that was performed): ______________________
2. Please provide one blood pressure reading and the corresponding date within the past 30 days ______________________
3. Please indicate the result of a urine protein dipstick reading and/or a 24-hour urine collection done within the past 30 days. ______________________
4. Is the patient receiving a 5-flurouracil based drug regimen? **(circle answer)** **Yes** **or** **No**
   If no, please explain why a 5-FU regimen is not to be given ______________________
   If yes, indicate the 5-FU regimen ______________________
5. Dose prescribed: ______________ Start date of therapy: ______________ Sig: ______________

Part C

1. Has the patient experienced a severe hemorrhagic event requiring medical intervention in the past 8 weeks? **(circle answer)** **Yes** **or** **No**
   If yes, please explain ______________________
2. Has the patient developed a gastrointestinal (GI) bleed due to GI perforation, abscess, wound dehiscence, or wound healing complications in the past 8 weeks? **(circle answer)** **Yes** **or** **No**
   If yes, please explain ______________________
3. Has the patient been receiving and tolerating Avastin® therapy for the past 8 weeks? **(circle answer)** **Yes** **or** **No**
   If no, please explain ______________________
4. If the patient has been on treatment for greater than 12 weeks, has the patient shown a beneficial response to the therapy? **(circle answer)** **Yes** **or** **No**
   If yes, please explain ______________________