anovo SPECIALTY PHARMACY

PURIXAN®
(mercaptopurine) oral suspension
Prescription Order Form

Phone: 844-288-5007
Fax: 855-813-2039

Patient Information *Please print

Last Name:	First Name:	SSN:	Sex: ☐M ☐F
Address:	City:	State:	Zip:
Phone: Day # ( )	Evening #: ( )	Cell # : ( )	
DOB:	Ht:	Wt:	Date Weight Taken: ___________
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #: ( )	

Insurance Information *Include copies of insurance cards

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:			
NPI:	DEA:	Medicaid UPIN:	State License #:
Address:			
City:	State:	Zip:	
Name of Contact Person:			Phone: ( )
Physician Email:			Fax: ( )

Prescription

PURIXAN ® (mercaptopurine) oral suspension 1 bottle = 2000mg/100mL (20mg/mL)

Sig: Take __________ mg daily Quantity to dispense ________bottles Refills ____________

PLEASE NOTE:
Because Purixan ® is only supplied in bottles containing 100mL, the actual day's supply provided by one bottle of Purixan ® will vary depending on the patient's daily dose. Purixan® is not available in amounts smaller than 100mL per bottle. Once opened, Purixan® should be used within 8 weeks.

Medical Necessity

Primary ICD-10 code ________________________________ **Therapy Start Date** ______________________________

Please check one ☐ C91.00 ☐ Other (ICD) _____ ☐ Other (ICD) _____

Allergies __________________________ NKDA ________

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by AnovoRx Manufacturer Services, LLC and its employees to assist in obtaining coverage for Purixan® and to assist in initiating or continuing Purixan®. I appoint AnovoRx Manufacturer Services, LLC as my agent for the sole purpose of conveying this prescription to the dispensing pharmacy. I certify that (a) any service arranged through AnovoRx Manufacturer Services, LLC on my behalf is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Purixan® or any other product or service for anyone, and (b) my decision to prescribe Purixan® was based solely on my determination of medical necessity, and that (c) I will not seek any reimbursement for any medication or service provided by or arranged through AnovoRx Manufacturer Services, LLC and paid by any government program or third-party insurer.

Signature: ___________________________ **Print Name:** ___________________________ **Date: Written:** _______________

Dispense as Written: ________________________
(Stamped Signatures Are Not Valid)

Substitution Allowed: ______________________________________
(Stamped Signatures Are Not Valid)

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

Form: PUR.RX.01
Effective Date: 05/01/2014
Revised 10/09/17