Hemangeol® (propranolol hydrochloride) oral solution 4.28 mg/mL

Patient Referral Form

Fax: 855-813-2039 Phone: 833-486-5950

anovo SPECIALTY PHARMACY

Please select one: ☐ **Newly Prescribed Patient** ☐ **Patient Currently on Hemangeol**

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

Hemangeol (propranolol hydrochloride) oral solution 4.28mg/mL

Qty to dispense: ☐ **30 day supply** ☐ **90 day supply**

Refills: _____

Week 1: Administer 0.15 mL/kg twice daily at least 9 hours apart during or after feeding.

Week 2: Administer 0.3 mL/kg twice daily at least 9 hours apart during or after feeding.

Week 3: Administer 0.4 mL/kg twice daily at least 9 hours apart during or after feeding as maintenance dose.

Special Instructions:

I certify that I have prescribed Hemangeol as described above for this patient, based on my professional judgement for a medically necessary purpose. I authorize the release of medical and/or other patient information relating to Hemangeol to agents of Eton Pharmaceuticals, Inc. and service providers (including, but not limited to pharmacies dispensing Hemangeol) to use and disclose as necessary for purposes including prior authorization, processing, and fulfillment of the prescription. I authorize CloudTop Health to prepare and submit prior authorization requests, appeal requests, and other related processing and administrative tasks on behalf of the prescriber and to receive notices in connection with requests which may include but is not limited to faxes, phone calls, mail, email, or any other form of communication. I authorize that this form (and the information included herein) may be provided to AnovoRx.

I certify I am prescribing Hemangeol 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)

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Patient Information

Last Name:	First Name:	Sex: ☐ M ☐ F

Medical Necessity

Primary diagnosis:	Date of Diagnosis:	Patient Age at Diagnosis:

Please check applicable ICD-10 code: Therapy Start Date: _____

☐ Hemangioma of skin and subcutaneous tissue (D18.01)

☐ Hemangioma of other sites (D18.09)

☐ Other ICD-10#: _____ Description: _____

☐ Hemangioma, unspecified site (D18.00)

Allergies: _____ ☐ NKDA

Confidentiality Statement

This message is intended only for the individual or entity to which it is addressed. It may contain information which is proprietary and confidential. It may also contain privileged, confidential information that is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 833-486-5950 to obtain instructions as to the proper destruction of the transmitted material.

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Hemangeol Questionnaire

Prescriber Information			
Prescriber Name / Title:		NPI:	
Address:	City:	State:	Zip:

Patient Information			
First Name:	Last Name:	DOB:	
Address:	City:	State:	Zip:

Clinical Information

What is the patient's diagnosis?

☐ Proliferating infantile hemangioma (IH) requiring systemic therapy ☐ Other

Please check all clinical features that necessitate systemic intervention per AAP guidelines:

☐ Airway/Vital Function ☐ Disfigurement ☐ Ocular ☐ Structural ☐ Ulceration

Has the patient's candidacy for the medication been confirmed according to the drug's package insert?

☐ Reviewed all contraindications and warnings (e.g. bronchial asthma or history of bronchospasm).

☐ Completed all necessary labs and monitoring (e.g. baseline heart rate and blood pressure).

Is the patient's age between 5 weeks to 5 months and the patient's weight greater than 2 kg (4.4 lbs)?

Age: _____ Weight: _____

In the prescriber's opinion, would alternatives not be effective?

☐ The alternatives would not be as effective for treating the patient's condition.

☐ The alternatives would likely have adverse effects.

☐ Stable on current medication and changing to an alternative would likely cause adverse effects.

Notes:

All information is true and accurate to the best of my knowledge.

Authorized Signature: _____ **Title:** _____

Please sign to validate.