Medical Clearance Form

*****PLEASE SIGN, DATE AND RETURN TO XPOSE® by Sandoz PSP via FAX 1-844-449-7673*****

Date:	
To:	XPOSE® by Sandoz Patient Support Program
Fax:	
From:	
Pages:	
Subject:	****Medical Clearance Immediate Action Required****

Thank you for enrolling your patient in the XPOSE® by Sandoz Patient Support Program. To proceed with the request for Riximyo® treatment, please provide us medical clearance for your patient,

Name: _____ **DOB:** _____

Please select the following: ☐ Initial ☐ Subsequent

1. Pre-Infusion Blood Work Completed ☐ Yes ☐ No
2. Date of blood work: _____
3. Proceed with Riximyo Treatment ☐ Yes ☐ No

Dosage/ Prescription :	**☐Riximyo –**
Pre-Medications:	**☐Acetaminophen 650 mg PO 30 min pre infusion** **☐Diphenhydramine 50 mg PO 30 min pre infusion** **☐Methylprednisolone 100 mg IV in 50 mL 0.9% Sodium Chloride Injection, USP 30 min pre infusion** **☐PRN Medications for Infusion Reactions as listed on Enrollment Form**
Additional Comments:	

Physician Name:	**License #:**
Physician Signature:	**Date:**
NCM Name:	**Cell:**
NCM Signature:	**Email:**