Anti-Infective Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

Patient Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Primary Phone: __________ DOB: __________

Alternate Phone: __________ Gender: ☐ Male ☐ Female

Email : ____________________

Last 4 digits SS#: __________

PRESCRIBER INFORMATION

Name: ____________________

State License #: __________ NPI #: __________

DEA #: ____________________

Address: ____________________

City, State Zip: ____________________

Phone: __________ Fax: __________

Contact Person: __________ Phone: __________

INSURANCE INFORMATION

If available, please fax copy of prescription insurance cards with this form (front and back).

PRESCRIPTION

Diagnosis and Clinical Information

Primary Diagnosis: ____________________ Height: __________

Secondary Diagnosis: ____________________ Weight: __________

Allergies: ____________________

Diabetic: ☐ Yes ☐ No Insulin Dependent ☐ Yes ☐ No

Therapy Ordered	**Anti-Infective Therapy 1**		**Anti-Infective Therapy 2**	
	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Ertapenem ☐ Ceftolozane / tazobactam ☐ Other:	Dose: Frequency: Start Date: Duration:	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Ertapenem ☐ Ceftolozane / tazobactam ☐ Other:	Dose: Frequency: Start Date: Duration:
Services Ordered	☐ Pharmacy only ☐ Home Health ☐ Nursing/HHA Name:		Is patient Homebound? ☐ Yes ☐ No	
Flushing	☐ NS 5 ml SASH and prn ☐ Heparin 20 units ☐ Heparin 100 units SASH and prn		Access: None ☐ or Type: __________ Date inserted: __________	

Following Physician: ____________________ Phone: ____________________

Anticipated time of Discharge Home: Time __________ Date __________

Hospital Name ____________________ Location ____________________

Referral Contact Name __________ Phone __________ Fax __________

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: **Date**:

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.