Oral Antibiotics Enrollment Form

Date: _____ **Needs by Date:** _____

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

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Email address: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

DIAGNOSIS AND CLINICAL INFORMATION

Primary Diagnosis: _____ Height: _____

Secondary Diagnosis: _____ Weight: _____

Allergies: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Sivextro	200mg	Once daily for 6 days		
☐ Zyvox	600mg	Every 12 hours for 10-14 days		
☐ Dificid	200mg	Twice a day for 10 days		
☐ Baraclude	0.5 to 1mg	Once daily		
☐ Cresemba	372mg	Initial: 372mg (isavuconazole 200mg) every 8 hours for 6 doses. Maintenance: 372mg (isavuconazole 200mg) once daily.		
☐ Pylera	(bismuth subcitrate potassium 140mg, metronidazole 125mg, tetracycline HCL 125mg) Each dose includes 3 capsules.	Take 4 time a day, after meals and at bedtime for 10 days.		
☐ Xifaxan	☐ 200 mg ☐ 550mg	Take 1 tablet 3 times daily for 14 days		

X _____
Physician's Signature (Date)

I authorize pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process.