

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 <i>(Complete the following or send patient demographic sheet)</i> 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: _____
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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
<input type="checkbox"/> Sivextro	200mg	Once daily for 6 days		
<input type="checkbox"/> Zyvox	600mg	Every 12 hours for 10-14 days		
<input type="checkbox"/> Difucid	200mg	Twice a day for 10 days		
<input type="checkbox"/> Baraclude	0.5 to 1mg	Once daily		
<input type="checkbox"/> Cresemba	372mg	Initial: 372mg (isavuconazole 200mg) every 8 hours for 6 doses. Maintenance: 372mg (isavuconazole 200mg) once daily.		
<input type="checkbox"/> 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.		
<input type="checkbox"/> Xifaxan	<input type="checkbox"/> 200 mg <input type="checkbox"/> 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.

IMPORTANT NOTICE: this facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.