



Oral Antibiotics

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

Injection Training: MD Office
 Pharmacy to Arrange

Ship To: Patient Home MD Office

MAIN POINT OF CONTACT

Name: _____

Phone: _____

PATIENT INFORMATION (Use this area or attach patient demographics)

Name: _____ Phone: _____ Phone 2: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

DOB: _____ SSN: _____ Sex: Male Female Height: _____ Weight: _____ lbs.

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ RxBin: _____ ID#: _____ RxBin: _____

RxGroup: _____ Pcn: _____ RxGroup: _____ Pcn: _____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis: _____ ICD10 Code: _____

Secondary Diagnosis: _____ ICD10 Code: _____

Previous Treatment: _____ AST: _____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Strength	Directions	QTY	Refill
<input type="checkbox"/> Sivextro	200 mg	Once daily for 6 days		
<input type="checkbox"/> Zyvox	600 mg	Every 12 hours for 10-14 days		
<input type="checkbox"/> Dificid	200 mg	Twice a day for 10 days		
<input type="checkbox"/> Baraclude	0.5 to 1 mg	Once daily		
<input type="checkbox"/> Cresemba	372 mg	Initial: 372 mg (isavuconazole 200 mg) every 8 hours for 6 doses. Maintenance: 372 mg (isavuconazole 200 mg) once daily		
<input type="checkbox"/> Pylera	(bismuth subcitrate potassium 140mg, metronidazole 125mg, tetracycline HCL 125mg) Each dose includes 3 capsules.	Take 4 times a day, after meals and at bedtime for 10 days		
<input type="checkbox"/> Xifaxan	<input type="checkbox"/> 200 mg <input type="checkbox"/> 550 mg	Take 1 tablet 3 times daily for 14 days		



Allergies: _____

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name: _____ NPI#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

***Prescriber Signature:** _____ **Date:** _____

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Please fax completed form to 1 (888) 294-9434