

BERGEN AVE DRUGS SIVEXTRO PRESCRIPTION REFERRAL FORM

Specialty Pharmacy

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Today's Date

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

NEW PATIENT CURRENT PATIENT

Last updated: May 2017

Patient Name First Name _____ Last Name _____ SS# _____ DOB _____ Height _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Giannotto's Specialty Pharmacy
 ICD-10 Code: _____ Allergies: _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____
 Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PATIENT CONDITION:

- Patient has a documented MRSA ABSSSI infection
- Patient cannot tolerate or is resistant to other MRSA sensitive antibiotics
- Other _____

WAS A CULTURE COMPLETED?

- Yes - results: **OR** No - rationale for use: _____

ANTIBIOTIC SUSCEPTIBILITY TESTED?

- Yes (fax results) **OR** No - rationale for use: _____

PREVIOUSLY UNSUCCESSFUL ANTIBIOTICS FOR TREATING THE PATIENT'S CURRENT INFECTION?

- Yes, other drugs used include:
 Medication: _____ Date: _____ Outcome: _____
 Medication: _____ Date: _____ Outcome: _____
- No other antibiotics have been used for the patient's current infection

SIVEXTRO

- 200 mg oral tablet
- 200 mg intravenous injection

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Administration for infusion patients:

- Provider's office
- Outpatient infusion center: _____
 Center affiliated with a hospital? Yes No
- Home infusion Agency: _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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