BERGEN AVE DRUGS
Specialty Pharmacy

SIVEXTRO PRESCRIPTION REFERRAL FORM

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

Today's Date

☐ **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**