IV 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 #: __________ Primary Language: __________
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: ____________________

Diabetic: ☐ Yes ☐ No Insulin Dependent ☐ Yes ☐ No

Services Ordered
- ☐ Pharmacy Only
- ☐ Home Health
- ☐ Nursing/HHA Name:

Is patient Homebound? ☐ Yes ☐ No

Flushing
- ☐ NS 5 ml SASH and prn
- ☐ Heparin 20 units
- ☐ Heparin 100 units SASH and prn

Access: None ☐
or Type: __________
Date inserted: __________

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Dalvance	1000mg/500mg	1000 mg IV followed by 500mg IV one week later		
☐ Orbactiv	1200mg	1200mg x 1 dose		
☐ Zerbaxa	IV 1.5g	1.5g every 8 hours for 7 days		
☐ Synercid	IV 7.5mg/kg	7.5mg/kg every 12 hours for at least 7 days		
☐ Cubicin	IV 4mg/kg	4mg/kg once daily for 7 to 14 days		
☐ Avycaz	IV 2.5g	2.5g every 8 hours for 7 to 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.*