MORRISTOWN PHARMACY

SIVEXTRO PRESCRIPTION REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960
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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** ____

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Please fax completed form to **Morristown Pharmacy** at **973 - 998 - 0288**

Visit us at **WWW.MORRISTOWNRX.COM** for online fillable forms.

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