SIVEXTRO REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ _____ Diagnosis _____
☐ **Yes** ☐ **No** Testing?
☐ **Yes** ☐ **No** Is Patient currently on therapy? Date of next blood work _____

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

PRESCRIPTION

☐ **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** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

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PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.