



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 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; 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.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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