ALLIED PHARMACY

Oral Antibiotics

Ph: 832-365-3420 Fax: 855-595-2955

MAIN POINT OF CONTACT

Name:_____

Phone:_____

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____

ID#:_____ RxBin:_____ ID#:_____ RxBin:_____

RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

Secondary Diagnosis:_____ ICD10 Code:_____

Previous Treatment:_____ AST:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Strength	Directions	QTY	Refill
☐ **Sivextro**	200 mg	Once daily for 6 days		
☐ **Zyvox**	600 mg	Every 12 hours for 10-14 days		
☐ **Dificid**	200 mg	Twice a day for 10 days		
☐ **Baraclude**	0.5 to 1 mg	Once daily		
☐ **Cresemba**	372 mg	Initial: 372 mg (isavuconazole 200 mg) every 8 hours for 6 doses. Maintenance: 372 mg (isavuconazole 200 mg) once daily		
☐ **Pylera**	(bismuth subcitrate potassium 140mg, metronidazole 125mg, tetracycline HCL 125mg) Each dose includes 3 capsules.	Take 4 times a day, after meals and at bedtime for 10 days		
☐ **Xifaxan**	☐ 200 mg ☐ 550 mg	Take 1 tablet 3 times daily for 14 days		

Allergies:

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address:_____ City:_____ State:____ Zip Code:_____

Phone:_____ Fax:_____

***Prescriber Signature:_____Date:_____**

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Please fax completed form to 1 855-595-2955