



Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION Deliver Here

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ DOB: _____

Alternate Phone: _____ Gender: Male Female

Email: _____

Last 4# of SS: _____

PRESCRIBER INFORMATION Deliver Here

Name: _____

State License #: _____ NPI: _____

DEA #: _____ Tax ID: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION If available, please fax copy of prescription insurance cards with this form (front and back).

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: _____

PRESCRIPTION				
MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Sivextro	200mg	Take 1 tablet once daily for 6 days		
<input type="checkbox"/> Zyvox	600mg	Take 1 tablet every 12 hours for 10-14 days		
<input type="checkbox"/> Difucid	200mg	Take 1 tablet twice a day for 10 days		
<input type="checkbox"/> Baraclude	0.5 to 1mg	Take 1 tablet once daily		
<input type="checkbox"/> Cresemba	372mg	Initial: 372mg (isavuconazole 200mg) every 8 hours for 6 doses. Maintenance: 372mg (isavuconazole 200mg) once daily.		
<input type="checkbox"/> Pylera	(bismuth subcitrate potassium 140mg, metronidazole 125mg, tetracycline HCL 125mg) Each dose includes 3 capsules.	Take 1 tablet 4 times a day, after meals and at bedtime for 10 days.		
<input type="checkbox"/> Xifaxan	<input type="checkbox"/> 200 mg <input type="checkbox"/> 550mg	Take 1 tablet 3 times daily for 14 days		

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: _____ Date: _____

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

I authorize Medical Center Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do 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. Pursuant to VA/OH/MOVT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289
3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102

