



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).

DIAGNOSIS AND CLINICAL INFORMATION

Primary Diagnosis: _____ Height: _____

Secondary Diagnosis: _____ Weight: _____

Allergies: _____

Diabetic: Yes No Insulin Dependent: Yes No

PRESCRIPTION

	Anti-Infective Therapy 1	Anti-Infective Therapy 2
Therapy Ordered	<input type="checkbox"/> Vancomycin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Cefepime <input type="checkbox"/> Daptomycin <input type="checkbox"/> Ertapenem <input type="checkbox"/> Ceftolozane/Tazobactam <input type="checkbox"/> Other: _____	<input type="checkbox"/> Vancomycin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Cefepime <input type="checkbox"/> Daptomycin <input type="checkbox"/> Ertapenem <input type="checkbox"/> Ceftolozane/Tazobactam <input type="checkbox"/> Other: _____
Services Ordered	<input type="checkbox"/> Pharmacy only <input type="checkbox"/> Home Health <input type="checkbox"/> Nursing/HHA Name: _____	
Flushing	<input type="checkbox"/> NS 5 ml SASH and prn Heparin <input type="checkbox"/> 20 units <input type="checkbox"/> Heparin 100 units SASH and prn	Dose: _____ Frequency: _____ Start Date: _____ Duration: _____
		Dose: _____ Frequency: _____ Start Date: _____ Duration: _____
		Is patient Homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Access: None <input type="checkbox"/> or Type: _____ Date inserted: _____

Following Physician: _____ Phone: _____

Anticipated time of Discharge Home: Time _____ Date _____

Hospital Name _____ Location _____

Referral Contact Name _____ Phone _____ Fax _____

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
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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/MO/VT 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

