Medical Center PHARMACY
Service Delivery Trust Since 1924

IV Antibiotics

Phone # 1-844-546-7577 • 619-263-1998
Fax # 1-844-240-2518 • 619-243-3245

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: _____
Diabetic: ☐ Yes ☐ No Insulin Dependent ☐ Yes ☐ No

Services Ordered
☐ Pharmacy Only
☐ Home Health
☐ Nursing/HHA Name:

Is patient Homebound? ☐ Yes ☐ No

Flushing
☐ NS 5 ml SASH and prn
☐ Heparin 20 units
☐ Heparin 100 units SASH and prn

Access: None ☐
or Type:
Date inserted:

PRESCRIPTION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Dalvance	1000mg/500mg	1000 mg IV followed by 500mg IV one week later		
☐ Orbactiv	1200mg	1200mg x 1 dose		
☐ Zerbaxa	IV 1.5g	1.5g every 8 hours for 7 days		
☐ Synercid	IV 7.5mg/kg	7.5mg/kg every 12 hours for at least 7 days		
☐ Cubicin	IV 4mg/kg	4mg/kg once daily for 7 to 14 days		
☐ Avycaz	IV 2.5g	2.5g every 8 hours for 7 to 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 Premissable** **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/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

ACCREDITED SPECIALTY PHARMACY urac ACCREDITED SPECIALTY PHARMACY