

PATIENT INFORMATION

Patient Name: _____	Phone: (____) - ____ - _____
Date of Birth: ____ / ____ / ____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Email: _____
SSN: ____ - ____ - ____	Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Email
Address: _____	Height: _____ in Weight: _____ lb Date: ____ / ____ / ____
City: _____ State: _____ Zip: _____	Allergies: _____ Medications: _____ (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____	ID#: _____	Group #: _____	RxBIN: _____	RxPCN: _____
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PRESCRIBER INFORMATION

Prescriber Name: _____	Phone: (____) - ____ - _____	Fax: (____) - ____ - _____
Address: _____	License #: _____	
City: _____ State: _____ Zip: _____	NPI #: _____	
Contact: _____ Clinic/Hospital Affiliation: _____	Medicaid Provider #: _____	

CLINICAL CONSIDERATIONS

Diagnosis: _____	Has patient received IV Baxdela™? <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunization History
ICD10: _____	Dates of IV therapy? _____	<input type="checkbox"/> Influenza
	Expected Discharge Date (if applicable): _____	Date: ____ / ____ / ____
	Oral Baxdela Start Date: _____	Culture Results:
	History of therapies tried/failed (please include dates): _____	

Rx

Medication	Directions	Quantity	Refills
<input type="checkbox"/> Baxdela™ (delafloxacin)	<input type="checkbox"/> 450 mg tablet every 12 hours for _____ days <input type="checkbox"/> Other: _____		

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ MD DO PA CRNP **Date:** ____ / ____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician/Clinic	Date Shipment Needed By: ____ / ____ / ____
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