MAIN POINT OF CONTACT
Name:_____
Phone:_____

ASP CARES
Oral Antibiotics
Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

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:_____**

Please fax completed form to 1 (888) 294-9434