P: 832-813-8932

F: 888-883-9901

ORBACTIV RX FORM

PATIENT INFORMATION

PATIENT NAME: _____ **DOB** _____/_____/_____ **PHONE:** (_____) - _____ - _____

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS

ORBACTIV ORDERS

☐ **1200MG TO BE INFUSED FOR A TOTAL OF ONE INFUSION, NO LESS THAN 3 HOURS**

PLEASE INDICATE PRE-MEDS IF NEEDED

BENADRYL IV _____ MG
REGLAN IV _____ MG
SOLUMEDROL IV _____ MG
ZOFRAN IV _____ MG
OTHER IV_____ MG

BENADRYL PO _____ MG
TYLENOL PO _____ MG
ZYRTEC PO _____ MG
ZOFRAN PO _____ MG
ZANTAC PO _____ MG
OTHER PO_____ MG

MEDICAL INFORMATION

DIAGNOSIS: _____ **ICD-10:** _____

ALLERGIES: _____ ☐ **N.K.D.A**

PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN NAME (PRINTED): _____ **NPI:** _____

PHONE: _____ **FAX:** _____ **CONTACT PERSON:** _____

PHYSICIAN NAME (SIGNED): _____ **DATE:** _____