



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: _____

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