MedicoRx Specialty
& HOME INFUSION PHARMACY

Baxdela Enrollment Form

Phone: 818-390-9696 / 855-265-7850 **Fax:** 818-390-9697

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Primary Phone: ______________ DOB: _____

Alternate Phone:__________ Gender: ☐ Male ☐ Female

Email : ______________________________

Last 4 digits SS#: ______________________

PRESCRIBER INFORMATION

Name: ______________________________

State License #: ________ NPI #: ________

DEA #: ______________________________

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).

Clinical Considerations

Diagnosis: ____

ICD-10: ______________________

Has patient received IV Baxdela? ☐ Yes ☐ No

Dates of IV therapy? __________________________

Expected Discharge Date (if applicable): ______________________

History of therapies tried/failed (please include dates):

Immunication History

☐ Influenza

Date: ______________

Medication	Directions	Quantity	Refills
Baxdela™ (delafloxacin)	☐ 450 mg tablet every 12 hours for ________ days ☐ Other: ____		

Ship to: ☐ Patient ☐ Physician/Clinic

Date Shipment Needed By: ________________

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: Date: ______________

CONFIDENTIALITY NOTICE

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