

Patient Information			
Patient Name:		Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City:	State: Zip:
Phone Number:		Alternate Phone Number:	Language:
Social Security Number:		E-Mail:	
Allergies:			<input type="checkbox"/> NKDA
<input type="checkbox"/> Pick Up / Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Alternative Address:			

**Insurance: Please fax copy of insurance card (front and back)**

Prescriber Information			
Practice Name:		Office Contact:	
Prescriber:		NPI:	DEA:
Practice Address:		City:	State: Zip:
Phone Number:		Fax Number:	

Clinical Information	
Diagnosis/ICD-10:	Culture results:
Prior Failed Medications:	

Prescription Information				
Medication	Dose	Directions	Quantity	Refills
Sivextro™ (Tedizolid Phosphate)	200 mg	Take 200 mg by mouth once daily	<input type="checkbox"/> 6 <input type="checkbox"/> _____	

Prescriber Signature and Date (Please sign and date below)			
_____		_____	
Substitution Permissible	Date	Dispense as Written	Date
<input type="checkbox"/> Check here to authorize Curexa™ and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"			