ORBACTIV (oritavancin) Referral Order Form

FAX (877) 637-6691

VASCO SPECIALTY-INFUSION

An AleraCare Company

WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions *indicate name of drug(s)

_____

Vasco Infusion can accept only original order forms from patients, and faxed order forms from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

ORBACTIV MEDICATION ORDERS

☐ Orbactive 1200mg **Infuse 1200mg as a 1 time dose.**

Patient Weight: _____ kg

INDICATION/DIAGNOSIS

☐ ABSSSI
☐ Other _____

***ICD-10** _____ **required**

_____
Referring Physician's Signature

_____
Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

APPOINTMENT DATE & TIME: _____
FOR OFFICE USE ONLY

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