

ORBACTIV (oritavancin) Referral Order Form



WWW.PACEINFUSION.COM

PH:330-625-4900

F: 330-685-9355

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

PACE Healthcare 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 _____

NOTES (ADDITIONAL INFO)

*ICD-10 _____ required

Referring Physician's Signature _____

Date _____

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

Important Notice: This information is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy the information contained in this correspondence. Please notify the sender immediately if you received this document in error and then destroy this document immediately.

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