

ORBACTIV / KIMYRSA

Provider Order Form rev. 12/23/2021



PATIENT INFORMATION

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight lbs/kg: _____

Patient Status: New to Therapy Continuing Therapy Next Due Date (if applicable): _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

ICD-10 CODE

- ABSSSI
- Other: _____

MEDICATION ORDER

Infuse 1200mg as a 1 time dose.

- Orbactiv 1200mg
- Kimyrsa 1200mg

SPECIAL INSTRUCTIONS

Provider Name (Print) Provider Signature Date

REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes) Current Medication History and Physical Report
- Lab Results Insurance Cards (front and back) Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ANA (SLE) Comprehensive Metabolic Panel, CBC with differential w/in past 3 months