

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).



Organ Transplant
Immunosuppressants
Prescription/Pharmacy Intake Form

Pharmacy: _____

Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ Ship To: [] Prescriber's Office [] Patient's Home [] Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ [] Male [] Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

Insurance provider (Please include copy of front and back of card): Primary _____ Secondary _____

ID #: _____ / _____ Policy/Group #: _____ / _____ Phone #: _____ / _____ [] Patient is eligible for Medicare

CLINICAL ASSESSMENT - Please complete ALL sections to avoid delays in filling prescription

(Please include all supporting material including but not limited to History and Physical, Progress Notes and Recent Labs)

[] Patient is new to therapy [] Patient is currently on therapy Start date: _____

[] Heart (Z94.1) [] Kidney (Z94.0) [] Liver (Z94.4) [] Lung (Z94.2) [] Intestines (Z94.82) [] Pancreas (Z94.83) [] Heart/Lung (Z94.3) [] Kidney/Pancreas (Z94.0/Z94.83) [] Bone Marrow (Z94.81)

Organ Transplanted: _____ Date of Transplant: _____ Date of Discharge: _____

Weight: _____ [] lb [] kg Date: _____ Height: _____ [] in [] cm Date: _____

Allergies: _____

MEDICATIONS

Astagraf XL (tacrolimus ER capsule)

[] 0.5mg _____ Qty _____ Refills _____

[] 1mg _____ Qty _____ Refills _____

[] 5mg _____ Qty _____ Refills _____

Cellcept (mycophenolate)

[] 250mg _____ Qty _____ Refills _____

[] 500mg _____ Qty _____ Refills _____

[] 200mg/ml _____ Qty _____ Refills _____

Envarsus XR (tacrolimus ER tablet)

[] 0.75mg _____ Qty _____ Refills _____

[] 1mg _____ Qty _____ Refills _____

[] 4mg _____ Qty _____ Refills _____

Gengraf (cyclosporine mod)

[] 25mg _____ Qty _____ Refills _____

[] 50mg _____ Qty _____ Refills _____

[] 100mg _____ Qty _____ Refills _____

[] 100mg/ml _____ Qty _____ Refills _____

Imuran (azathioprine)

[] 50mg _____ Qty _____ Refills _____

Myfortic (mycophenolic acid)

[] 180mg _____ Qty _____ Refills _____

[] 360mg _____ Qty _____ Refills _____

Neoral (cyclosporine mod)

[] 25mg _____ Qty _____ Refills _____

[] 100mg _____ Qty _____ Refills _____

[] 100mg/ml _____ Qty _____ Refills _____

Prednisone

[] 5mg _____ Qty _____ Refills _____

[] 10mg _____ Qty _____ Refills _____

[] 20mg _____ Qty _____ Refills _____

Prograf (tacrolimus)

[] 0.5mg _____ Qty _____ Refills _____

[] 1mg _____ Qty _____ Refills _____

[] 5mg _____ Qty _____ Refills _____

Prograf Granules (tacrolimus for oral suspension)

[] 0.2mg _____ Qty _____ Refills _____

[] 1mg _____ Qty _____ Refills _____

Rapamune (sirolimus)

[] 0.5mg _____ Qty _____ Refills _____

[] 1mg _____ Qty _____ Refills _____

[] 2mg _____ Qty _____ Refills _____

[] 1mg/ml _____ Qty _____ Refills _____

Sandimmune (cyclosporine)

[] 25mg _____ Qty _____ Refills _____

[] 100mg _____ Qty _____ Refills _____

[] 100mg/ml _____ Qty _____ Refills _____

Zortress (everolimus)

[] 0.25mg _____ Qty _____ Refills _____

[] 0.5mg _____ Qty _____ Refills _____

[] 0.75mg _____ Qty _____ Refills _____

[] 1mg _____ Qty _____ Refills _____

Other: _____ Qty _____ Refills _____

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: [] Email [] Phone [] Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.