

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
Gastrointestinal and Miscellaneous
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

Gastrointestinal

Pepcid (famotidine) [ ] 20mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_ [ ] 40mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Prevacid (lansoprazole) [ ] 30mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Prilosec (omeprazole) [ ] 20mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_ [ ] 40mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Protonix (pantoprazole) [ ] 40mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Zantac (ranitidine) [ ] 150mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_ [ ] 300mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Other: [ ] \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Miscellaneous

Aspirin [ ] 81mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_ [ ] 325mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Hydrochlorothiazide [ ] 25mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_ [ ] 50mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Lasix (furosemide) [ ] 20mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_ [ ] 40mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_ [ ] 80mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

Norvasc (amlodipine) [ ] 5mg \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_ [ ] 10mg \_\_\_\_\_ 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