Phone: 845-789-5648
Fax: 845-789-4104
NCPDP 5851476
NPI: 1457297335

TRANSPLANT REFERRAL FORM

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ **Z94.0** Kidney ☐ **Z94.1** Heart ☐ **Z94.2** Lung ☐ **Z94.4** Liver ☐ **Z94.81** Bone Marrow ☐ **Z94.83** Pancreas
☐ **Z94.82** Intestines ☐ **Z94.84** Peripheral Stem Cells ☐ **Z94.89** Other specified organ or tissue _____
Dates of: Diagnosis _____ Transplant _____ Discharge _____ Est. Discharge Time _____
☐ **Yes** ☐ **No** Was there a prior transplant failure of the same organ?
☐ **Yes** ☐ **No** Does patient have Medicare Part A coverage at time of transplant?
☐ **Yes** ☐ **No** Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary.
*Agency of choice: _____ Date training occurred _____
Injection training not necessary: ☐ MD office trained patient ☐ Patient already independent ☐ Referred to alternate trainer

PRESCRIPTION

IMMUNOSUPPRESSANTS

☐ PROGRAF (TACROLIMUS) ☐ 0.5mg ☐ 1mg ☐ 5mg	SIG: _____	QTY: _____	Refill: _____
☐ RAPAMUNE (SIROLIMUS) ☐ 1mg ☐ 2mg	SIG: _____	QTY: _____	Refill: _____
☐ GENGRAF (CYCLOSPORINE) ☐ 25mg ☐ 100mg	SIG: _____	QTY: _____	Refill: _____
☐ NEORAL (CYCLOSPORINE) ☐ 25mg ☐ 100mg	SIG: _____	QTY: _____	Refill: _____
☐ CELLCEPT (MYCOPHENOLATE) ☐ 250mg ☐ 500mg	SIG: _____	QTY: _____	Refill: _____
☐ MYFORTIC (MYCOPHENOLIC ACID) ☐ 180mg ☐ 360mg	SIG: _____	QTY: _____	Refill: _____
☐ PREDNISONE ☐ 5mg	SIG: _____	QTY: _____	Refill: _____
☐ OTHER _____	SIG: _____	QTY: _____	Refill: _____

☐ PCP PROPHYLAXIS	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
☐ CMV PROPHYLAXIS	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
☐ THRUSH (CANDIDA)	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
☐ GASTROINTESTINAL	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
☐ ANTIHYPERTENSIVES	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
☐ HEMATOPOIETICS	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____
	_____	Strength _____	SIG: _____	QTY: _____	Refill: _____

DIABETIC SUPPLIES

Is patient a ☐ **Type 1** (insulin-dependent) or ☐ **Type 2** (non-insulin dependent) diabetic? ☐ Not a Diabetic

GLUCOMETER SIG: _____ QTY: _____ Refill: _____
TEST STRIPS SIG: _____ QTY: _____ Refill: _____
LANCETS SIG: _____ QTY: _____ Refill: _____
INSULIN SYRINGES **0.5cc** SIG: _____ QTY: _____ Refill: _____
SHORT-ACTING INSULIN _____ **LONG-ACTING INSULIN** _____

☐ ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.