



Heart Transplant Prescription Enrollment Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821
Single Point of Contact: (724) 515-7053

1. Patient Information

Start Date: _____ Ship to: ___ Patient ___ Office ___ Other

Patient Name: _____ M / F DOB: _____ Soc.Sec # _____

Address: _____ Phone #: _____

Caregiver: _____ Allergies: _____ Alt Phone #: _____

2. Clinical Information Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization

ICD -10/ Diagnosis Code: _____ Date of Transplant: _____ Organ: _____

Special Instructions: _____ Medicare Part A: yes / no Medicare Part B: yes / no

3. Prescription Information If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided

Astagraf XL®	Strength:	Crestor®	Strength:	Oscal®	500 mg	Valcyte®	450 mg
Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills
Baby Aspirin EC	81 mg	Lasix®	Strength:	Prednisone	Strength:	Zocor®	Strength:
Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills
Bactrim®	800/160 mg _(DS)	Lipitor®	Strength:	Prilosec®	Strength:	Zovirax®	400 mg
Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills
Cardizem CD	Strength:	Magnesium Oxide	400 mg	Prograf®	Strength:		Strength:
Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills
Cellcept®	__ 250mg cap __ 500 mg tab	Mycelex Troche®	10 mg	Rapamune®	1mg		Strength:
Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills
Colace®	100 mg	Nexium®	40 mg	Revatio®	20 mg		Strength:
Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills	Sig:	QTY Refills

Please fax list of patient's other medications & choose packaging: ___ **AccuPAC®** ___ **Bottles** ___ Check here to learn more about AccuPAC®
___ Check here for medications to be dispensed as BRAND, otherwise generics will be substituted when available

4. Prescriber and Shipping Information

Prescriber (print): _____ Office Contact: _____

Pref. Method of Contact: ___ phone ___ fax ___ email Contact email: _____

Office Address: _____

Phone: _____ Fax: _____ NPI: _____

Prescriber's Signature: _____ Date: _____ DEA: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information **Please fax a copy of insurance card front and back. Enlarge if possible.**

IMPORTANT NOTICE: this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately.

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