TRANSPLANT PRESCRIPTION REFERRAL FORM

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821
FAX: 877-526-8823

Start Date

Ship To: ☐ Patient ☐ Office ☐ **Other**

1. Patient Information: **Please fax front and back copy of the insurance card (Prescription and Medical)**

Patient: _____ Male / Female DOB: _____ Soc. Sec. #_____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Clinical Information: **Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization**

Transplant Date: _____ Anticipated Discharge Date: _____ Organ Transplanted: _____

3. Prescription Information: **If you need a medication not listed please contact us**

Medication	Dose/Strength	Max. Daily Dosage	Sig.	Qty.	Refills
☐ Prograf®	☐ 0.5 mg ☐ 1 mg ☐ 5 mg				
☐ Rapamune® (sirolimus)	☐ 0.5 mg ☐ 1 mg ☐ 2 mg ☐ 1 mg/ml				
☐ Neoral®	☐ 25 mg ☐ 100 mg ☐ 100 mg/ml				
☐ Myfortic® (mycophenolic acid)	☐ 180 mg ☐ 360 mg				
☐ Cellcept®	☐ 200 mg/ml ☐ 250 mg ☐ 500 mg				
☐ Valcyte™ (Valganciclovir)	☐ 450 mg ☐ 50 mg/ml				
☐ VFend	☐ 50 mg ☐ 200 mg ☐ 40 mg/ml				
☐ Zortress	☐ 0.25 mg ☐ 0.5 mg ☐ 0.75 mg				
☐ Hectoria	☐ 0.5 mg ☐ 1 mg ☐ 5 mg				
☐ Transplant Kit	☐ 1 package (BP monitor, therm., pill cutter, pill box, blood pressure cuff)		Use as directed	1	
☐					
☐					

Please fax a list of patient's other medications: Fax to: (877-526-8823) **Packaging:** ☐ **Bottles** ☐ **AccuPac™**

4. Prescriber and Shipping Information:

Prescriber (print): _____ **Office Contact:** _____

Preferred method of contact: ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:** _____

Office Address: _____

Phone: _____ **fax:** _____ **NPI:** _____ **DEA:** _____

Prescriber's Signature: _____ **Date:** _____

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

5. Patient Support Programs (optional): **Please sign below to enroll in the pharmaceutical company assisted patient support program**

Patient Signature: _____ **Date:** _____

6. Insurance Information: Please fax a copy of the insurance card (front and back)