



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
<input type="checkbox"/> Prograf®	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 5 mg				
<input type="checkbox"/> Rapamune® (sirolimus)	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 1 mg/ml				
<input type="checkbox"/> Neoral®	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 100 mg/ml				
<input type="checkbox"/> Myfortic® (mycophenolic acid)	<input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg				
<input type="checkbox"/> Cellcept®	<input type="checkbox"/> 200 mg/ml <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg				
<input type="checkbox"/> Valcyte™ (Valganciclovir)	<input type="checkbox"/> 450 mg <input type="checkbox"/> 50 mg/ml				
<input type="checkbox"/> VFend	<input type="checkbox"/> 50 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 40 mg/ml				
<input type="checkbox"/> Zortress	<input type="checkbox"/> 0.25 mg <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 0.75 mg				
<input type="checkbox"/> Hectoria	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 5 mg				
<input type="checkbox"/> Transplant Kit	<input type="checkbox"/> 1 package (BP monitor, therm., pill cutter, pill box, blood pressure cuff)		Use as directed	1	
<input type="checkbox"/>					
<input type="checkbox"/>					

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 authorize AccuServ 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)

*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. Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.