Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

AccuSERV® PHARMACY

Transplant Prescription Enrollment Form

Clear 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*

Please fax a list of patient's other medications and choose packaging: _____◯ **AccuPAC®** _____◯ **Bottles**

☐ **Check Here to get more information about our custom compliance packaging AccuPAC®**

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
☐	Astagraf XL®	◯0.5mg ◯1mg ◯5mg		_____ caps	
☐	Bactrim® SMZ/TMP	◯400mg/80mg(SS) ◯800mg/160mg(DS)		_____ tabs	
☐	Cellcept®	◯250mg caps ◯500mg tabs ◯225mL suspension		_____ caps _____ tabs _____ mL	
☐	Imuran®	◯50mg		_____ tabs	
☐	Lasix®	◯20mg ◯40mg ◯80mg		_____ tabs	
☐	Myfortic®	◯180mg ◯360mg		_____ tabs	
☐	Neoral®	◯25mg ◯100mg		_____ gel caps	
☐	Prednisone	_____mg		_____ tabs	
☐	Prograf®	◯0.5mg ◯1mg ◯5mg		_____ caps	
		◯5mg/mL injection (1mL ampules)		☐10 ampules	
☐	Rapamune®	◯0.5mg ◯1mg ◯2mg		_____ tabs	
		◯1 mg/mL solution		_____mL	
☐	Transplant Kit®	1 BP monitor, thermometer, pill cutter, pill box, BP cuff		☐1 Kit	
☐	Valcyte®	◯450mg ◯50mg/mL solution		_____ tabs _____mL	
☐	VFend®	◯50mg ◯200mg		☐30 tablets	
		◯40mg/mL suspension		☐75mL -14day exp.	
☐	Zortress®	◯0.25mg ◯0.5mg ◯0.75mg		_____ tabs	
☐					

4. Prescriber and Shipping Information

Prescriber (print) : _____ Office Contact: _____

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

Office Address: _____

Phone: _____ Fax: _____ NPI:_____

Prescriber 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.

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