Transplant Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____
email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____
Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____
Fax: (____) - ____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

TXRX-17-02

CLINICAL CONSIDERATIONS

Diagnosis:
☐ Z94.0 Kidney Transplant ☐ Z94.4 Liver Transplant
☐ Z94.1 Heart Transplant ☐ Z94.2 Lung Transplant
☐ Z94.83 Pancreas Transplant
☐ Z94.82 Intestine Transplant
☐ Other:_____

Date of Transplant: ____ /____ / ____
Anticipated Discharge Date: ____ /____ / ____
Prior Therapies (please include dates):

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞ ☐ Transplant Kit (BP Monitor/Cuff, Thermometer, Pill Cutter & Pill Box)

Medication	Dose/Strength	Directions	Quantity	Refills
Prograf® (tacrolimus)	☐ 0.5 mg capsules ☐ 1 mg capsules ☐ 5 mg capsules			
Astagraf XL® (tacrolimus extended-release)	☐ 0.5 mg capsules ☐ 1 mg capsules ☐ 5 mg capsules			
Envarsus XR® (tacrolimus extended-release)	☐ 0.75 mg tablets ☐ 1 mg tablets ☐ 4 mg tablets			
Neoral® (cyclosporine, modified)	☐ 25 mg capsules ☐ 100 mg capsules ☐ 100 mg/ml solution			
Gengraf® (cyclosporine, modified)	☐ 25 mg capsules ☐ 100 mg capsules ☐ 100 mg/ml solution			
Sandimmune® (cyclosporine, non-modified)	☐ 25 mg capsules ☐ 100 mg capsules ☐ 100 mg/ml solution			
Cellcept® (mycophenolate mofetil)	☐ 250 mg capsules ☐ 500 mg tablets ☐ 200 mg/ml suspension			
Myfortic® (mycophenolic acid, delayed-release)	☐ 180 mg tablets ☐ 360 mg tablets			
Rapamune® (sirolimus)	☐ 0.5 mg tablets ☐ 1 mg tablets ☐ 2 mg tablets ☐ 1 mg/ml solution			
Zortress® (everolimus)	☐ 0.25 mg tablets ☐ 0.5 mg tablets ☐ 0.75 mg tablets			
Prednisone	☐ 5 mg tablets			
Valcyte® (valganciclovir)	☐ 450 mg tablets ☐ 50 mg/ml solution			
Vfend® (voriconazole)	☐ 50 mg tablets ☐ 200 mg tablets ☐ 40 mg/ml suspension			

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____