



Fax: _____
Phone: _____

Transplant Enrollment Form

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis — Please include diagnosis name with ICD-10 code

ICD-10 _____ Description _____

Transplant Type:

Heart Kidney Liver Lung Kidney Pancreas

Other _____

Date of Transplant _____

Test Results:

WNL:

SCr/CrCl _____ Yes No

LFTs _____ Yes No

Additional Information

Therapy: New Reauthorization Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Astagraf XL (tacrolimus)				
<input type="checkbox"/> Cellcept (mycophenolate mofetil)				
<input type="checkbox"/> Envarsus XR (tacrolimus)				
<input type="checkbox"/> Gengraf (cyclosporine modified)				
<input type="checkbox"/> Myfortic (mycophenolic acid)				
<input type="checkbox"/> Neoral (cyclosporine modified)				
<input type="checkbox"/> Nulojix (belatacept)				
<input type="checkbox"/> Prograf (tacrolimus)				
<input type="checkbox"/> Rapamune (sirolimus)				
<input type="checkbox"/> Sandimmune (cyclosporine)				
<input type="checkbox"/> Zortress (everolimus)				
<input type="checkbox"/> Prednisone				
<input type="checkbox"/> Other: _____				

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office Other _____ Date _____ Needs by Date _____

Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____

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