

TRANSPLANT REFERRAL FORM



PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT	
Primary Caregiver Name (if applicable)		
Caregiver Email	Caregiver Phone	
Alternate Contact Name		
Alternate Contact Email	Alternate Contact Phone	

PRESCRIBER INFORMATION

Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber Specialty		
Prescriber State License #	DEA #	
NPI #	Medicaid UPIN #	
Office Contact Name	Title	
Office Email		
Office Phone	Office Fax	
Preferred Contact Method (check one)	<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	Best Time to Call

INSURANCE INFORMATION

Insurance Provider	Plan ID #	
BIN#:	PCN#:	RX Group#:
Insured's Name	Relationship to Patient	

Eligible for Medicare (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list Medicare #
Prescription Card (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list carrier

Please include a copy of the front and back of insurance card.

CLINICAL INFORMATION

Prescription Type (check one)	<input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment	Therapy Start Date
Sample/Starter Product Provided? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Provide Qty	Sample Date Provided
Date of Transplant	Date of Discharge	Date Medication Needed
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (check one) <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)	

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Ship to Address (check one)	<input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)	
Other/Concomitant Medications		
ICD-10 Codes	<input type="checkbox"/> Kidney (Z94.0) <input type="checkbox"/> Kidney/Pancreas (Z94.0/Z94.83) <input type="checkbox"/> Heart (Z94.1) <input type="checkbox"/> Lung (Z94.2) <input type="checkbox"/> Heart/Lung (Z94.3) <input type="checkbox"/> Liver (Z94.4) <input type="checkbox"/> Bone Marrow (Z94.81) <input type="checkbox"/> Intestines (Z94.82) <input type="checkbox"/> Pancreas (Z94.83)	

We accept Escribe and fax prescriptions. A faxable prescription form is attached.

TRANSPLANT PRESCRIPTIONS

MAIN INFORMATION (MUST BE FILLED OUT TO PROCESS PAGES TOGETHER FOR OFFICIAL PATIENT RECORDS)

Patient Last Name	Patient First Name	DOB	
Address			
City	State	ZIP	
Date of Issue			

Prescriber Name		
Prescriber Address		
City	State	ZIP
NPI #	DEA #	

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS

Prescriber Signature

DAW (Dispense as Written)

____/____/____
Date

Supervising Physician Signature (where required by state law)

____/____/____
Date

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions: _____

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