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)	☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT	
Primary Caregiver/Alt Contact Name (If applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title
Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax	Referral Contact Email
Office Phone	Office Fax
Practice / Facility Name	
Address	
City	State / ZIP
Prescriber Name / Specialty	
Prescriber State License #	DEA #
NPI #	Medicaid UPIN #

INSURANCE INFORMATION

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

Eligible for Medicare (check one)	☐ Yes ☐ No	If yes, list Medicare #
Prescription Card (check one)	☐ Yes ☐ No	If yes, list carrier

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

CLINICAL INFORMATION

Prescription Type	☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date
Sample/Starter Product Provided? ☐ Yes ☐ No	If yes, Provide Qty	Date Sample Provided
Date of Transplant	Date of Discharge	Date Medication Needed
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	Allergies ☐ NKDA ☐ Drug Allergies (please list)	
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Other/Concomitant Medications		
ICD-10 Codes	☐ Kidney (Z94.0) ☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Heart (Z94.1) ☐ Lung (Z94.2) ☐ Heart/Lung (Z94.3) ☐ Liver (Z94.4) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Pancreas (Z94.83) ☐ Skin Transplant (Z94.5) ☐ Bone Transplant (Z94.6) ☐ Corneal Transplant (Z94.7) ☐ Stem Cell Transplant (Z94.84) ☐ Other ______________	

We accept Escribe and fax prescriptions.

REV.0421

P 855.896.9254 | **F** 877.645.7514 | 10004 S. 152nd St, Suite A, Omaha NE 68138

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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		

Practice / Facility Name		
Practice Address		
City	State	ZIP
NPI #	DEA #	

PRESCRIPTION INFORMATION

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. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS	DAW (Dispense as Written)
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

Total RXs ______

______________________________ _____ /_____ /_____

Prescriber Signature Date

______________________________ _____ /_____ /_____

Supervising Physician Signature (where required by state law) Date

The information contained in this document will become a legal prescription.* ***Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. *If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.*

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