

TRANSPLANT REFERRAL FORM (Page 1 of 2)

PHONE 888.370.1724 | FAX 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender	<input type="checkbox"/> M <input type="checkbox"/> F	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/Alt Contact Name (If applicable)			Alt Contact Email			Alt Contact Phone

PRESCRIBER INFORMATION

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

\* Please include a copy of the front and back of insurance card \*

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment			
Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed
Other/Concomitant Medications (please list)			
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list) <input type="checkbox"/> Other (please list)			
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)			
Patient Height (cm/in)		Patient Weight (kg/lbs)	Date Obtained
ICD-10 Codes <input type="checkbox"/> Kidney (Z94.0) <input type="checkbox"/> Kidney/Pancreas (Z94.0/Z94.83) <input type="checkbox"/> Heart (Z94.1) 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) <input type="checkbox"/> B25 CMV disease <input type="checkbox"/> B25.9 CMV disease, unspecified <input type="checkbox"/> Other Code Description			

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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
IMMUNOSUPPRESSANTS				
<input type="checkbox"/> Azathioprine	<input type="checkbox"/> 50 mg tablet <input type="checkbox"/> 50 mg/mL cmpd susp			
<input type="checkbox"/> Cyclosporine modified	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg capsule <input type="checkbox"/> 100 mg/mL solution (unbreakable bottle of 50 mL)			
<input type="checkbox"/> Everolimus	<input type="checkbox"/> 0.25 mg tablet <input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 0.5 mg tablet <input type="checkbox"/> 2.5 mg tablet <input type="checkbox"/> 0.75 mg tablet <input type="checkbox"/> 5 mg tablet			
<input type="checkbox"/> Mycophenolate	<input type="checkbox"/> 250 mg capsule <input type="checkbox"/> 500 mg tablet <input type="checkbox"/> 200 mg/mL suspension (unbreakable bottle of 160ml)			
<input type="checkbox"/> Mycophenolic acid	<input type="checkbox"/> 180 mg tablet <input type="checkbox"/> 360 mg tablet			
<input type="checkbox"/> Nulojix (belatacept)	<input type="checkbox"/> 250 mg vial			
<input type="checkbox"/> Prednisone	<input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 10 mg tablet <input type="checkbox"/> 2.5 mg tablet <input type="checkbox"/> 20 mg tablet <input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 5mg/mL solution			
<input type="checkbox"/> Prednisolone	<input type="checkbox"/> 5 mg/mL solution <input type="checkbox"/> 5 mg/5 mL solution <input type="checkbox"/> 15 mg/5 mL solution			
<input type="checkbox"/> Prograf granules	<input type="checkbox"/> 0.2 mg <input type="checkbox"/> 1 mg			
<input type="checkbox"/> Sirolimus	<input type="checkbox"/> 0.5 mg tablet <input type="checkbox"/> 1 mg/mL solution (unbreakable bottle of 60 mL) <input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2 mg tablet			

Total RXs

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	Date
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)	

**Note:** The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

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## MAIN INFORMATION

(MUST BE FILLED OUT TO PROCESS PAGES TOGETHER)

Patient Last Name	Patient First Name	DOB	Date of Issue	
Patient Address	City	State	ZIP	
Prescriber Name	NPI #	DEA #		
Prescriber Address	City	State	ZIP	

## PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
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### IMMUNOSUPPRESSANTS CONTINUED

<input type="checkbox"/> Envarsus XR (Tacrolimus ER)	<input type="checkbox"/> 0.75 mg tablet <input type="checkbox"/> 1 mg tablet	<input type="checkbox"/> 4 mg tablet		
<input type="checkbox"/> Tacrolimus IR	<input type="checkbox"/> 0.5 mg capsule <input type="checkbox"/> 1 mg capsule <input type="checkbox"/> 5 mg capsule <input type="checkbox"/> 0.5 mg/mL cmpd susp			

### ANTIFUNGALS

<input type="checkbox"/> Clotrimazole	<input type="checkbox"/> 10 mg troche			
<input type="checkbox"/> Fluconazole	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 150 mg tablet <input type="checkbox"/> 200 mg tablet <input type="checkbox"/> 10 mg/mL suspension (unbreakable bottle of 35 mL)			
<input type="checkbox"/> Nystatin	<input type="checkbox"/> 100,000 u/mL suspension			

### ANTIVIRALS

<input type="checkbox"/> Livtency™	<input type="checkbox"/> 200 mg Tablet  Post-transplant CMV infection refractory to current treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No  Anticipated Treatment Length: _____ weeks	<b>STANDARD DOSE</b> <input type="checkbox"/> Take two tablets (400 mg) by mouth twice daily, with or without food  <b>ADJUSTED DOSING (PER LIVTENCITY PRESCRIBING INFORMATION, ADJUSTED DOSING IS RECOMMENDED FOR THE FOLLOWING CONCOMITANT MEDICATIONS):</b>  Carbamazepine <input type="checkbox"/> Take four tablets (800 mg) by mouth twice daily, with or without food  Phenobarbital <input type="checkbox"/> Take six tablets (1,200 mg) by mouth twice daily, with or without food  Phenytoin <input type="checkbox"/> Take six tablets (1,200 mg) by mouth twice daily, with or without food		
<input type="checkbox"/> Valganciclovir	<input type="checkbox"/> 450 mg tablet <input type="checkbox"/> 50 mg/mL solution (unbreakable bottle of 88 mL)			

### PCP PROPHYLAXIS/ANTIBIOTICS

<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> 250 mg tablet <input type="checkbox"/> 500 mg tablet <input type="checkbox"/> Cipro 250 mg/5 mL suspension (unbreakable bottle of 100 mL)			
<input type="checkbox"/> Dapsone	<input type="checkbox"/> 25 mg tablet <input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 2 mg/mL cmpd suspension			
<input type="checkbox"/> SMZ/trimethoprim	<input type="checkbox"/> 400 mg/80 mg SS <input type="checkbox"/> 800 mg/160 mg DS <input type="checkbox"/> 200 mg/40 mg/5 mL susp			

### MISCELLANEOUS

<input type="checkbox"/> Other _____				
<input type="checkbox"/> Other _____				

### WELCOME KIT

<input type="checkbox"/> Standard Kit	Includes: Lip balm, Sunscreen, Lotion, Tote Bag, Thermometer, Pill Box
<input type="checkbox"/> Add Ons	Select up to 2: <input type="checkbox"/> Scale <input type="checkbox"/> Blood Pressure Monitor <input type="checkbox"/> Blood Glucose Monitoring Kit

Total RXs \_\_\_\_\_

Prescriber Signature

Date

Supervising Physician Signature (where required by state law)

Date

DAW (Dispense as Written)

Date

Brand Necessary (must handwrite)

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