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-19-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ Z94.0 Kidney Transplant ☐ Z94.4 Liver Transplant
☐ Z94.1 Heart Transplant ☐ Z94.2 Lung Transplant
☐ Z94.83 Pancreas Transplant ☐ Z94.3 Heart and Lung 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			
☐ **Imuran®** (azathioprine)	☐ 50 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 ☐ 1 mg tablets			
☐ **Prednisone**	☐ 5 mg tablets ☐ Other:_____			
☐ **Bactrim™** (SMZ/TMP)	☐ SS 400/80 mg tablets ☐ DS 800/160 mg tablets			
☐ **Valcyte®** (valganciclovir)	☐ 450 mg tablets ☐ 50 mg/ml solution			
☐ **Zovirax®** (acyclovir)	☐ 200 mg capsules ☐ 400 mg tablets ☐ 800 mg tablets			
☐ **Vfend®** (voriconazole)	☐ 50 mg tablets ☐ 200 mg tablets ☐ 40 mg/ml suspension			
☐ **Nystatin Oral Suspension**	☐ 100,000 units/mL			
☐ **Other:**_____				

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: ____ /____ / ____

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