Organ Transplant
Prescription & Pharmacy Intake Form

evers SPECIALTY PHARMACY

Phone: 1-718-762-7400
Fax: 1-718-762-7404
Toll Free: 1-888-93-EVERS

Provider Representative | **Phone** | **Date Needed** | **Ship to** ☐ Specialty Care Center ☐ Patient's Home ☐ Prescriber's Office ☐ Other_____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ ☐ Male ☐ Female
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____
Insurance Provider (**Please include copy of front and back of card**): _____
ID #: _____ Policy/Group #: _____ Phone #: _____
Name of Insured: _____ Employer: _____
Relationship to Patient: ☐ Self ☐ Other: _____ ☐ Patient is Eligible for Medicare
Prescription Card: ☐ Yes ☐ No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Patient is Currently on Therapy (Start Date: _____)

Primary ICD-9 and Condition Description:
_____

Organ Transplanted: _____
Date of Transplant: _____

Current Weight: _____
Date: _____
Height (pediatrics): _____
Date: _____

Other Health Conditions: _____
_____
Allergies: _____
_____
Concomitant Medications: _____
_____
_____

PRESCRIPTION INFORMATION

Medication	Dose/Directions/Freq	Qty	Refills
Azathioprine ☐ 50 mg			
Cellcept® ☐ 250 mg ☐ 500 mg			
Gengraf® ☐ 25mg ☐ 100 mg			
Myfortic® ☐ 180 mg ☐ 360 mg			
Neoral® ☐ 25 mg ☐ 100 mg			
Rapamune® ☐ 0.5 mg ☐ 1 mg ☐ 2 mg			
Sandimmune® ☐ 25 mg ☐ 100 mg			
Prednisone ☐ 1 mg ☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 20 mg ☐ 50 mg			
Prograf® ☐ 0.5 mg ☐ 1 mg ☐ 5 mg			
Zortress® ☐ 0.25 mg ☐ 0.5 mg ☐ 0.75 mg			
☐ Other: _____			

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 substitution: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____ Practice/Facility Name: _____
Address: _____ Office Contact: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Fax: _____ Best Time to Call: _____
State License #: _____ DEA #: _____ NPI#: _____ Medicaid UPIN #: _____
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.
Prescriber's Signature Required: _____ Date: _____