

Organ Transplant

Prescription & Pharmacy Intake Form



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 <input type="checkbox"/> 50 mg			
Cellcept® <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg			
Gengraf® <input type="checkbox"/> 25mg <input type="checkbox"/> 100 mg			
Myfortic® <input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg			
Neoral® <input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg			
Rapamune® <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg			
Sandimmune® <input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg			
Prednisone <input type="checkbox"/> 1 mg <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 50 mg			
Prograf® <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 5 mg			
Zortress® <input type="checkbox"/> 0.25 mg <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 0.75 mg			
<input type="checkbox"/> 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: _____

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.
IMPORTANT WARNING: This is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employer or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.
Drug names are the property of their respective owners.