



STAR CARE PHARMACY

"The First Wealth is Health"

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Toll Free: 888-216-STAR (7827)

TRANSPLANT REFERRAL FORM

Date: _____ Attn: _____

Ship to Patient Physician Office Nurse/Training

Patient Name _____
 Address _____ Suite# _____
 City _____ State _____ Zip _____
 Home Tel _____ Work Tel _____
 Cell _____ Email _____
 Date of Birth _____ SS# _____
 Male Female Weight _____ Height _____

Prescriber's Name _____
 License# _____ DEA# _____
 NPI# _____ UPIN# _____
 Practice Name _____
 Office Contact _____
 Address _____ Suite# _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____

Insurance Information (Complete or attach copies of cards)

Primary Insurance: _____ Insured's Name: _____
 ID#: _____ City: _____ State: _____ Phone: () _____ - _____
 Group #: _____ Employer: _____

Diagnostic & Clinical Information

ICD-10 Diagnosis Code: Heart (Z94.1) Liver (Z94.4) Pancreas (Z94.83) Kidney (Z94.0) Lung (Z94.2)
 Bone Marrow (Z94.81) Intestines (Z94.82) Peripheral Stem Cells (Z94.84) Other specified organ or tissue (Z94.89) _____
 Date of Diagnosis _____ Date of Transplant _____ Date of Discharge _____ Est. Discharge Time _____
 Was there a prior transplant failure of the same organ? Yes No
 Allergies _____

Prescription

IMMUNOSUPPRESSANTS

<input type="checkbox"/> PROGRAF (tacrolimus) <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 5mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> NEORAL (cyclosporine) <input type="checkbox"/> 25mg <input type="checkbox"/> 100mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> PREDNISON <input type="checkbox"/> 5mg QTY _____ Refill x _____ Sig _____
<input type="checkbox"/> RAPAMUNE (sirolimus) <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> CELLCEPT (mycophenolate) <input type="checkbox"/> 250mg <input type="checkbox"/> 500mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> OTHER _____ Strength _____ QTY _____ Refill x _____ Sig _____
<input type="checkbox"/> GENGRAF (cyclosporine) <input type="checkbox"/> 25mg <input type="checkbox"/> 100mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> MYFORTIC (mycophenolic acid) <input type="checkbox"/> 180mg <input type="checkbox"/> 360mg QTY _____ Refill x _____ Sig _____	<input type="checkbox"/> OTHER _____ Strength _____ QTY _____ Refill x _____ Sig _____

<input type="checkbox"/> PCP PROPHYLAXIS	<input type="checkbox"/> THRUSH (CANDIDA)	<input type="checkbox"/> ANTIHYPERTENSIVES
<input type="checkbox"/> CMV PROPHYLAXIS	<input type="checkbox"/> GASTROINTESTINAL	<input type="checkbox"/> HEMATOPOIETICS
Strength _____	QTY _____ Refill x _____	Sig _____

DIABETIC SUPPLIES

Is patient a Type 1 (insulin-dependent) or Type 2 (non-insulin dependent) diabetic? Not a Diabetic

_____ **GLUCOMETER** **TEST STRIPS** **LANCETS** **INSULIN SYRINGES 0.5cc**

SHORT-ACTING INSULIN _____ **LONG-ACTING INSULIN** _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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