MORRISTOWN PHARMACY

TRANSPLANT REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960
Tel : 973 - 998 - 0287 | Fax : 973 - 998 - 0288

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Last updated: May 2017

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

Diagnosis ☐ Heart (Z94.1) ☐ Liver (Z94.4) ☐ Pancreas (Z94.83) ☐ Kidney (Z94.0) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Lung (Z94.2) ☐ 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 Does patient have Medicare Part A coverage at time of transplant? ☐ Yes ☐ No

Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary. ☐ Yes ☐ No *Agency of choice:

Date training occurred ☐ Injection training not necessary Reason: ☐ MD office trained patient ☐ Patient already independent ☐ Referred to alternate trainer

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

IMMUNOSUPPRESSANTS

PROGRAF (tacrolimus) 0.5mg 1mg 5mg
QTY ____ Refill x ____ Sig ____

RAPAMUNE (sirolimus) 1mg 2mg
QTY ____ Refill x ____ Sig ____

GENGRAF (cyclosporine) 25mg 100mg
QTY ____ Refill x ____ Sig ____

NEORAL (cyclosporine) 25mg 100mg
QTY ____ Refill x ____ Sig ____

CELLCEPT (mycophenolate) 250mg 500mg
QTY ____ Refill x ____ Sig ____

MYFORTIC (mycophenolic acid) 180mg 360mg
QTY ____ Refill x ____ Sig ____

PREDNISONE 5mg
QTY ____ Refill x ____ Sig ____

OTHER ____
QTY ____ Refill x ____ Sig ____

OTHER ____
QTY ____ Refill x ____ Sig ____

OTHER ____
QTY ____ Refill x ____ Sig ____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

PCP PROPHYLAXIS	____	Strength ____	QTY ____	Refill x ____	Sig ____
CMV PROPHYLAXIS	____	Strength ____	QTY ____	Refill x ____	Sig ____
THRUSH (candida)	____	Strength ____	QTY ____	Refill x ____	Sig ____
	____	Strength ____	QTY ____	Refill x ____	Sig ____
GASTROINTESTINAL	____	Strength ____	QTY ____	Refill x ____	Sig ____
ANTIHYPERTENSIVES	____	Strength ____	QTY ____	Refill x ____	Sig ____
	____	Strength ____	QTY ____	Refill x ____	Sig ____
	____	Strength ____	QTY ____	Refill x ____	Sig ____
HEMATOPOIETICS	____	Strength ____	QTY ____	Refill x ____	Sig ____
	____	Strength ____	QTY ____	Refill x ____	Sig ____

DIABETIC SUPPLIES

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

____ **GLUCOMETER** QTY ____ Refill x ____ Sig ____ **TEST STRIPS** QTY ____ Refill x ____ Sig ____ **LANCETS** QTY ____ Refill x ____ Sig ____

INSULIN SYRINGES 0.5cc QTY ____ Refill x ____ Sig ____ **SHORT-ACTING INSULIN** ____ **LONG-ACTING INSULIN** ____

Any known allergies? ____ Yes ____ No
List ____

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

Please fax completed form to **Morristown Pharmacy** at **973 - 998 - 0288**

Visit us at **WWW.MORRISTOWNRX.COM** for online fillable forms.