Procare PHARMACY

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Transplant Prescription Referral Form (Form 9A)

Date Medication Needed: _____ **Ship To:** Patient's Home Prescriber's Office Pick-up (store location): _____ Injection training by pharmacy?

1: Patient Information

Patient Name: **Birthdate:** _____ **Sex:** Male Female **Height:** **Weight:** _____ lbs. kg.

Soc. Sec. #: **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** **State:** **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

_____ _____ **DEA#:** **NPI#:** _____ **Tax ID#:** _____

Address: **Phone:** ( ) - _____ **Fax:** ( ) - _____

City: _____ **State:** **Zip:** **Key Contact:** _____ **Phone:** ( ) - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Transplant Date: _____ **Anticipated Discharge Date:** _____ **Organ Transplanted (choose one):**

4: Prescription Information

Medication	Dose/Strength	Max. Daily Dosage	Sig	Qty.	Refills
Prograf®	0.5mg 1mg 5mg				
Tacrolimus (Compounded Tacrolimus Liquid)	0.5mg/1ml 1mg/1ml				
Rapamune® (Sirolimus)	0.5mg 1mg 2mg 1mg/ml				
Neoral®	25mg 100mg 100mg/ml				
Myfortic® (Mycophenolic Acid)	180mg 360mg				
Cellcept®	200mg/ml 250mg 500mg				
Valcyte™ (Valganciclovir)	450mg 50mg/ml				
VFend	50mg 200mg 40mg/ml				
Zortress	0.25mg 0.5mg 0.75mg				
Hecoria	0.5mg 1mg 5mg				
Transplant Kit (BP monitor, therm., pill cutter, pill box, blood pressure cuff) Cuff Size: S M L	1 package		Use as directed	1	

PRIOR AUTHORIZATION APPLICATION TO INSURANCE AND PATIENT SUPPORT PROGRAM ARE AVAILABLE AT PROCARE PHARMACY

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____