



Specialty Pharmacy

Transplant Referral Form

TODAY'S DATE: _____
<input type="checkbox"/> NEW START <input type="checkbox"/> CONTINUATION OF THERAPY
SHIP TO: <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> KERR DRUG STORE: _____
DATE SHIPMENT NEEDED: _____

GENERAL INFORMATION

PATIENT NAME (FIRST, LAST): _____		DOB: _____	
ADDRESS: _____	CITY: _____	STATE: _____	ZIP: _____
SS#: _____	HOME#: _____	CELL#: _____	WORK#: _____
ALLERGIES: _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	WEIGHT: _____	HEIGHT: _____
CURRENT MEDS: _____			
PHYSICIAN NAME: _____		PRACTICE/HOSPITAL: _____	
ADDRESS: _____	CITY: _____	STATE: _____	ZIP: _____
PHONE#: _____	FAX#: _____	STATE LIC#: _____	DEA#: _____
NURSE/KEY OFFICE CONTACT: _____		NPI#: _____	

INSURANCE INFORMATION

PRIMARY INSURANCE: _____		EMPLOYER: _____	
CARDHOLDER NAME: _____	ID#: _____	GROUP#: _____	PHONE#: _____
SECONDARY INSURANCE: _____	ID#: _____	GROUP#: _____	PHONE#: _____

STATEMENT OF MEDICAL NECESSITY

TYPE(S) OF TRANSPLANT: Kidney Liver Pancreas Heart Lung(s) Small Bowel Islet Cell Other _____

PRESCRIPTION INFORMATION

<h3>CALCINEURIN/mTOR INHIBITORS</h3> <p><input type="checkbox"/> Prograf® 5 mg capsules QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Prograf® 1 mg capsules QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Neoral® 100 mg capsules QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Neoral® 25 mg capsules QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Sandimmune® 100 mg capsules QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Sandimmune® 25 mg capsules QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Rapamune® <input type="checkbox"/> 1 mg tablets <input type="checkbox"/> 2 mg tablets QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Brand Medically Necessary <input type="checkbox"/> Generic Permissible</p>	<h3>STEROIDS</h3> <p><input type="checkbox"/> Prednisone _____ mg QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Prednisolone _____ mg <input type="checkbox"/> tablets <input type="checkbox"/> solution (3 mg/mL) QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Other _____ mg QTY: _____ Sig: _____ Refills: _____</p>	<h3>SUPPORTIVE MEDICATIONS</h3> <p><input type="checkbox"/> Aspirin _____ mg QTY: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Dipyridamole _____ mg QTY: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Docosate Sodium 100 mg capsules QTY: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Famotidine 20 mg tablets QTY: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Ferrous Sulfate 325 mg tablets QTY: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Omeprazole 20 mg capsules QTY: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Ranitidine 150 mg tablets QTY: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Ursodiol 300 mg capsules QTY: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Other _____ mg QTY: _____ Refills: _____</p> <p><input type="checkbox"/> Other _____ mg QTY: _____ Refills: _____</p>
<h3>ANTI-PROLIFERATIVES</h3> <p><input type="checkbox"/> Cellcept® <input type="checkbox"/> 500 mg tablets <input type="checkbox"/> 250 mg capsules QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Myfortic® <input type="checkbox"/> 360 mg tablets <input type="checkbox"/> 180 mg tablets QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Azathioprine® _____ mg QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Brand Medically Necessary <input type="checkbox"/> Generic Permissible</p>	<h3>ID PROPHYLAXIS</h3> <p><input type="checkbox"/> Bactrim® <input type="checkbox"/> SS (400/80 mg) <input type="checkbox"/> DS (800/160 mg) QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Dapsone <input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Atovaquone Suspension 750 mg/5 mL QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Acyclovir QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Valcyte® QTY: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Other QTY: _____ Sig: _____ Refills: _____</p>	

** If you would like brand name, please write "Brand Medically Necessary". Please note that Kerr Health Specialty Pharmacy will dispense our formulary product unless otherwise specified.*

Physician Signature: _____ Date: _____