

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).

Organ Transplant

Antifungals, Antivirals, PCP Prophylaxis/Antibiotics

Prescription/Pharmacy Intake Form

Pharmacy: _____
Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ Ship To: Prescriber's Office Patient's Home Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ Male Female
Address: _____
City: _____ State: _____ Zip code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
Insurance provider (Please include copy of front and back of card): Primary _____ Secondary _____
ID #: _____ / _____ Policy/Group #: _____ / _____ Phone #: _____ / _____ Patient is eligible for Medicare

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

(Please include all supporting material including but not limited to History and Physical, Progress Notes and Recent Labs)

Patient is new to therapy Patient is currently on therapy Start date: _____
 Heart (Z94.1) Kidney (Z94.0) Liver (Z94.4) Lung (Z94.2) Intestines (Z94.82) Pancreas (Z94.83) Heart/Lung (Z94.3) Kidney/Pancreas (Z94.0/Z94.83) Bone Marrow (Z94.81)
Organ Transplanted: _____ Date of Transplant: _____ Date of Discharge: _____
Weight: _____ lb kg Date: _____ Height: _____ in cm Date: _____
Allergies: _____

MEDICATIONS

Antifungals	PCP Prophylaxis/Antibiotics
Nystatin Oral Susp. <input type="checkbox"/> 100,000u/ml _____ Qty _____ Refills _____	Bactrim SS (SMZ/TMP) <input type="checkbox"/> 400/80mg _____ Qty _____ Refills _____
Mycelex (clotrimazole troche) <input type="checkbox"/> 10mg _____ Qty _____ Refills _____	Bactrim DS (SMZ/TMP) <input type="checkbox"/> 800/160mg _____ Qty _____ Refills _____
Diflucan (fluconazole) <input type="checkbox"/> 100mg _____ Qty _____ Refills _____	Dapsone <input type="checkbox"/> 100mg _____ Qty _____ Refills _____
Other: <input type="checkbox"/> _____ Qty _____ Refills _____	Mepron Susp. (atovaquone) <input type="checkbox"/> 750mg/5ml _____ Qty _____ Refills _____
Antivirals	Zithromax (azithromycin) <input type="checkbox"/> 250mg _____ Qty _____ Refills _____ <input type="checkbox"/> 500mg _____ Qty _____ Refills _____
Valcyte (valgancyclovir) <input type="checkbox"/> 450mg _____ Qty _____ Refills _____	Cipro (ciprofloxacin) <input type="checkbox"/> 250mg _____ Qty _____ Refills _____ <input type="checkbox"/> 500mg _____ Qty _____ Refills _____
Zovirax (acyclovir) <input type="checkbox"/> 200mg _____ Qty _____ Refills _____ <input type="checkbox"/> 400mg _____ Qty _____ Refills _____ <input type="checkbox"/> 800mg _____ Qty _____ Refills _____	Levaquin (levofloxacin) <input type="checkbox"/> 250mg _____ Qty _____ Refills _____ <input type="checkbox"/> 500mg _____ Qty _____ Refills _____ <input type="checkbox"/> 750mg _____ Qty _____ Refills _____
Other: <input type="checkbox"/> _____ Qty _____ Refills _____	Other: <input type="checkbox"/> _____ Qty _____ Refills _____

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____
Address: _____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax: _____
Email: _____ Best time to call: _____ Preferred method of contact: Email Phone Fax
State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

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 after their signature.
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 on one of the lines below.

_____ Dispense as written _____ Substitution permitted _____ Date _____

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.
The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.
Drug names are the property of their respective owners.