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

Gastrointestinal and Miscellaneous

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

Gastrointestinal

Pepcid (famotidine)
- ☐20mg ________________________ Qty ____ Refills ___
- ☐40mg ________________________ Qty ____ Refills ___

Prevacid (lansoprazole)
- ☐30mg ________________________ Qty ____ Refills ___

Prilosec (omeprazole)
- ☐20mg ________________________ Qty ____ Refills ___
- ☐40mg ________________________ Qty ____ Refills ___

Protonix (pantoprazole)
- ☐40mg ________________________ Qty ____ Refills ___

Zantac (ranitidine)
- ☐150mg ________________________ Qty ____ Refills ___
- ☐300mg ________________________ Qty ____ Refills ___

Other:
- ☐ ________________________ Qty ____ Refills ___

Miscellaneous

Aspirin
- ☐81mg ________________________ Qty ___ Refills ____
- ☐325mg ________________________ Qty ___ Refills ____

Hydrochlorothiazide
- ☐25mg ________________________ Qty ___ Refills ____
- ☐50mg ________________________ Qty ___ Refills ____

Lasix (furosemide)
- ☐20mg ________________________ Qty ___ Refills ____
- ☐40mg ________________________ Qty ___ Refills ____
- ☐80mg ________________________ Qty ___ Refills ____

Norvasc (amlodipine)
- ☐5mg ________________________ Qty ___ Refills ____
- ☐10mg ________________________ Qty ___ Refills ____

Other:
- ☐ ________________________ 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.

©2022 All rights reserved. 082222