



Transplant Order Form

2506 Lakeland Drive, Suite 201, Jackson, Mississippi 39232
 Pharmacy phone: (866) 420-4041 Pharmacy fax: (601) 420-4040
 www.transcriptpharmacy.com

Patient Information

Patient name _____
 Address _____
 City _____ State _____ Zip _____
 Home phone _____ Cell _____
 DOB _____ SSN _____
 Drug allergies _____ Male Female
 Discharge date _____ Time _____

Prescriber Information

Prescriber name _____ Lic# _____
 DEA# _____ Tax ID _____
 Transplant Center _____
 Contact _____ Pager _____
 Address _____ Rm/FL _____
 City _____ State _____ Zip _____
 Office Phone _____ Fax _____

Insurance, Medicare or Medicaid Information

Primary Insurance _____ Secondary Insurance (*If applicable*) _____
 Policy # _____ Group _____ Policy # _____ Group _____
 Insurance phone _____ Insurance phone _____
 Prescription Drug Coverage: Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ PCN/ID# (if avail.) _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

Clinical Information

Medical Necessity

- Heart (V42.1)
- Kidney (V42.0)
- Pancreas (V42.83)
- Intestines (V42.84)
- Other: _____ ICD-9: _____
- Liver (V42.7)
- Bone Marrow (V42.81)
- Lung (V42.6)
- Peripheral Stem Cells (V42.82)

Additional Information

Transplant date: ____/____/____
 Was there a prior transplant failure of the same organ? Yes No
 Did patient have Medicare A coverage at time of transplant? Yes No
 Will patient be enrolled in Medicare B at time of discharge? Yes No
 Comments _____

| Drug Name | Strength | Directions for Use | Qty | Refills | DAW* |
|---|---|--------------------|-----|---------|------|
| <input type="radio"/> Cellcept® (Mycophenolate Mofetil) | | | | | |
| <input type="radio"/> Prograf® (Tacrolimus) | | | | | |
| <input type="radio"/> Neoral® (Cyclosporine Modified) | | | | | |
| <input type="radio"/> Rapamune® (Sirolimus) | | | | | |
| <input type="radio"/> Imuran® (Azathioprine) | | | | | |
| <input type="radio"/> Myfortic® (Mycophenolic Acid EC) | | | | | |
| <input type="radio"/> Valcyte® (Valganciclovir) | 450 MG | | | | |
| <input type="radio"/> Cytovene® (Ganciclovir) | | | | | |
| <input type="radio"/> Mycelex® (Clotrimazole troches) | | | | | |
| <input type="radio"/> Diflucan® (Fluconazole) | | | | | |
| <input type="radio"/> Bactrim™/Septra® (SMZ/TMP) | <input type="radio"/> SS <input type="radio"/> DS | | | | |
| <input type="radio"/> Nystatin suspension | 100,000U/ML | | | | |
| <input type="radio"/> Prednisone | | | | | |
| <i>Other Medications:</i> | | | | | |
| | | | | | |

Deliver to: Patient's home Discharge Rx's to Hospital, then remaining refills to patient's home
 All discharge orders include: BP Cuff, digital thermometer, medical alert ID bracelet 7 Day QID pill box

***PRODUCT SUBSTITUTION PERMITTED UNLESS OTHERWISE INDICATED**

We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

Prescriber name or signature _____ Office Contact Name (Nurse, MA, Other) _____ Preferred phone number & extension _____ Date _____