Faxed prescription will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Transplant Prescription Referral Form

1403 Highway 6 Suite 700A, Sugar Land, TX 77478 **Phone: 832.944.6112** **Fax: 832.944.6116**

Choice Infusion Center "Infuse to better health"

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)

Prescriber Information

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

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

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

Diagnosis/Clinical Information

Please FAX recent clinical notes, Labs, Tests, with the prescription to expidite the Prior Authorization

Transplant Date: _____ **Anticipated Discharge Date:** _____ **Organ Transplanted:** _____

Prescription Information

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

Date Medication Needed: ____/____/_____ **Ship To:** ____ Patient's Home _____ Prescriber's Office _____ Pick-up (store location): _____ Injection Training by Pharmacy

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: **Date:**

Prescriber Signature: Prescriber, please sign and date below

Dispense as written **Date:** **Substitution Permissable** **Date**

# of Prescriptions: _____