

Transplant Prescription Referral Form

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.



AssureRx

PHARMACY

2026 Babcock Road, Suite # 104 • San Antonio- 78229, TX
 Ph : 210.467.5174 • Fax: 210.467.5184 • www.AssureRxPharmacy.com

Date Medication Needed: _____

Ship To: Patient's Home Prescriber's Office Pick-up _____

Injection training by pharmacy? _____



1: 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)



2: Prescriber Information

DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____



3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Transplant Date: _____ Anticipated Discharge Date: _____ Organ Transplanted (choose one): _____



4: Prescription Information

Medication	Dose/Strength	Max. Daily Dosage	Sig	Qty.	Refills
Progra®	0.5mg 1mg 5mg				
Tacrolimus (Compounded Tacrolimus Liquid)	0.5mg/1ml 1mg/1ml				
Rapamune® (Sirolimus)	0.5mg 1mg 2mg 1mg/ml				
Neoral®	25mg 100mg 100mg/ml				
Myfortic® (Mycophenolic Acid)	180mg 360mg				
Cellcept®	200mg/ml 250mg 500mg				
Valcyte™ (Valganciclovir)	450mg 50mg/ml				
VFend	50mg 200mg 40mg/ml				
Zortress	0.25mg 0.5mg 0.75mg				
Hecoria	0.5mg 1mg 5mg				
Transplant Kit (BP monitor, therm., pill cutter, pill box, blood pressure cuff) Cuff Size: S M L	1 package		Use as directed	1	

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 Permissible

Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____