Transplant

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Simple steps to submitting a referral

PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-9 or ICD-10)

☐ Heart (V42.1) ☐ Liver (V42.7) ☐ Pancreas (V42.83) ☐ Kidney (V42.0)
☐ Bone Marrow (42.81) ☐ Intestines (V42.84) ☐ Lung (V42.6) ☐ Peripheral Stem Cells (42.82)
☐ Other specified organ or tissue (42.89): _____
☐ ICD-10 Code & Description: _____

Height: _____ in/cm Weight: _____ kg/lbs Allergies: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
Immunosuppressants				
☐ Prograf® (tacrolimus)	0.5mg			
☐ Prograf® (tacrolimus)	1mg			
☐ Prograf® (tacrolimus)	5mg			
☐ Gengraf® (cyclosporine)	25mg			
☐ Gengraf® (cyclosporine)	100mg			
☐ Neoral® (cyclosporine)	25mg			
☐ Neoral® (cyclosporine)	100mg			
☐ Cellcept® (mycophenolate)	250mg			
☐ Cellcept® (mycophenolate)	500mg			
☐ Myfortic® (mycophenolic acid)	180mg			
☐ Myfortic® (mycophenolic acid)	360mg			
☐ Rapamune® (sirolimus)	1mg			
☐ Rapamune® (sirolimus)	2mg			
☐ Zortress®	0.25mg			
☐ Zortress®	0.5mg			
☐ Zortress®	0.75mg			
☐ Prednisone	5mg			
PCP Prophylaxis				
☐				
CMV Prophylaxis				
☐				
Thrush (Candida)				
☐				
☐				
Gastrointestinal				
☐				
☐				

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
Antihypertensives				
☐				
☐				
☐				
☐				
Diabetic Supplies				
☐ Insulin ☐ Non Insulin Diagnosis Code: _____				
☐ Not a Diabetic				
☐ _____Glucometer	N/A			
☐ _____Test Strips	N/A			
☐ _____Lancets	N/A			
☐ 0.5cc Insulin Syringes	N/A			
☐ Short-Acting Insulin:				
_____				
☐ Long-Acting Insulin:				
_____				
☐				
☐				
Hematopoietics				
☐				
☐				
OTHER MEDICATIONS				
☐				
☐				
☐				
☐				
☐				
☐				

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

Prescriber's Signature: _____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.