ADVANCED PHARMACY SOLUTIONS

TRANSPLANT REFERRAL FORM

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ACCREDITED

Today's Date _____
Date Needed _____

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ APS Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current Medications (if necessary, please fax a complete list)_____

Primary Insurance_____ Member ID Number_____
RxBIN_____ RxPCN_____ RxGrp_____
Member Services Number_____Provider Services Number_____

ICD-10 Diagnosis Code: ☐ Heart (Z94.1) ☐ Liver (Z94.4) ☐ Pancreas (Z94.83) ☐ Kidney (Z94.0) ☐ Lung (Z94.2)
☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Peripheral Stem Cells (Z94.84) ☐ Other specified organ or tissue (Z94.89) _____
Date of Diagnosis _____ Date of Transplant _____ Date of Discharge _____ Est. Discharge Time _____
Was there a prior transplant failure of the same organ? ☐Yes ☐ No
Allergies _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

IMMUNOSUPPRESSANTS

☐ **PROGRAF® (tacrolimus)**
☐ 0.5mg ☐ 1mg ☐ 5mg
QTY _____ Refill x _____
Sig _____

☐ **NEORAL® (cyclosporine)**
☐ 25mg ☐ 100mg
QTY_____ Refill x _____
Sig _____

☐ **PREDNISONE®**
☐ 5mg
QTY _____ Refill x _____
Sig _____

☐ **RAPAMUNE® (sirolimus)**
☐ 1mg ☐ 2mg
QTY _____ Refill x _____
Sig _____

☐ **CELLCEPT® (mycophenolate)**
☐ 250mg ☐ 500mg
QTY_____ Refill x _____
Sig _____

☐ **OTHER** _____
Strength _____
QTY_____ Refill x _____
Sig _____

☐ **GENGRAF® (cyclosporine)**
☐ 25mg ☐ 100mg
QTY _____ Refill x _____
Sig _____

☐ **MYFORTIC® (mycophenolic acid)**
☐ 180mg ☐ 360mg
QTY _____ Refill x _____
Sig _____

☐ **OTHER** _____
Strength _____
QTY_____ Refill x _____
Sig _____

☐ **PCP PROPHYLAXIS** ☐ **THRUSH (CANDIDA)** ☐ **ANTIHYPERTENSIVES**
☐ **CMV PROPHYLAXIS** ☐ **GASTROINTESTINAL** ☐ **HEMATOPOIETICS**
Strength _____ QTY_____ Refill x _____Sig _____

DIABETIC SUPPLIES

Is patient a ☐ Type 1 (insulin-dependent) or ☐ Type 2 (non-insulin dependent) diabetic? ☐ Not a Diabetic
_____ **GLUCOMETER** ☐ **TEST STRIPS** ☐ **LANCETS** ☐ **INSULIN SYRINGES** 0.5cc
☐ **SHORT-ACTING INSULIN**_____ ☐ **LONG-ACTING INSULIN** _____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.