

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).



Organ Transplant
Gastrointestinal and Miscellaneous
Prescription/Pharmacy Intake Form

Pharmacy: _____

Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ Ship To: [] Prescriber's Office [] Patient's Home [] Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ [] Male [] Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

Insurance provider (Please include copy of front and back of card): Primary _____ Secondary _____

ID #: _____ / _____ Policy/Group #: _____ / _____ Phone #: _____ / _____ [] Patient is eligible for Medicare

CLINICAL ASSESSMENT - Please complete ALL sections to avoid delays in filling prescription

(Please include all supporting material including but not limited to History and Physical, Progress Notes and Recent Labs)

[] Patient is new to therapy [] Patient is currently on therapy Start date: _____

[] Heart (Z94.1) [] Kidney (Z94.0) [] Liver (Z94.4) [] Lung (Z94.2) [] Intestines (Z94.82) [] Pancreas (Z94.83) [] Heart/Lung (Z94.3) [] Kidney/Pancreas (Z94.0/Z94.83) [] Bone Marrow (Z94.81)

Organ Transplanted: _____ Date of Transplant: _____ Date of Discharge: _____

Weight: _____ [] lb [] kg Date: _____ Height: _____ [] in [] cm Date: _____

Allergies: _____

MEDICATIONS

Gastrointestinal

Pepcid (famotidine) Qty _____ Refills _____

[] 20mg _____ [] 40mg _____

Prevacid (lansoprazole) Qty _____ Refills _____

[] 30mg _____

Prilosec (omeprazole) Qty _____ Refills _____

[] 20mg _____ [] 40mg _____

Protonix (pantoprazole) Qty _____ Refills _____

[] 40mg _____

Zantac (ranitidine) Qty _____ Refills _____

[] 150mg _____ [] 300mg _____

Other: Qty _____ Refills _____

[] _____

Miscellaneous

Aspirin Qty _____ Refills _____

[] 81mg _____ [] 325mg _____

Hydrochlorothiazide Qty _____ Refills _____

[] 25mg _____ [] 50mg _____

Lasix (furosemide) Qty _____ Refills _____

[] 20mg _____ [] 40mg _____

[] 80mg _____

Norvasc (amlodipine) Qty _____ Refills _____

[] 5mg _____ [] 10mg _____

Other: Qty _____ Refills _____

[] _____

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: [] Email [] Phone [] Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

*** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA ***

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.