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

Antifungals, Antivirals, PCP Prophylaxis/Antibiotics

Prescription/Pharmacy Intake Form

☐Central Pharmacy: ___________________________
☐Retail/Community 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

Antifungals

Nystatin Oral Susp.
☐100,000u/ml ___________________________ Qty____ Refills____

Mycelex (clotrimazole troche)
☐10mg ___________________________ Qty____ Refills____

Diflucan (fluconazole)
☐100mg ___________________________ Qty____ Refills____

Other:
☐ ___________________________ Qty____ Refills____

Antivirals

Valcyte (valgancyclovir)
☐450mg ___________________________ Qty____ Refills____

Zovirax (acyclovir)
☐200mg ___________________________ Qty____ Refills____
☐400mg ___________________________ Qty____ Refills____
☐800mg ___________________________ Qty____ Refills____

Other:
☐ ___________________________ Qty____ Refills____

PCP Prophylaxis/Antibiotics

Bactrim SS (SMZ/TMP)
☐400/80mg ___________________________ Qty ____ Refills ___

Bactrim DS (SMZ/TMP)
☐800/160mg ___________________________ Qty ____ Refills ___

Dapsone
☐100mg ___________________________ Qty ____ Refills ___

Mepron Susp. (atovaquone)
☐750mg/5ml ___________________________ Qty ____ Refills ___

Zithromax (azithromycin)
☐250mg ___________________________ Qty ____ Refills ___
☐500mg ___________________________ Qty ____ Refills ___

Cipro (ciprofloxacin)
☐250mg ___________________________ Qty ____ Refills ___
☐500mg ___________________________ Qty ____ Refills ___

Levaquin (levofloxacin)
☐250mg ___________________________ Qty ____ Refills ___
☐500mg ___________________________ Qty ____ Refills ___
☐750mg ___________________________ Qty ____ Refills ___

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

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.

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Drug names are the property of their respective owners.

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