LeMed SPECIALTY PHARMACY | Transplant Prescription Referral Form

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Lemedrx.com
If you need a medication not listed, please contact us.

Date Medication Needed: _____ **Ship To:** Patient's Home Prescriber's Office Pick-up

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

Provider Name: _____ **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:** _____ **ICD-10:** _____

4: Prescription Information

Medication	Dose/Strength	DAW ?	Sig	Qty.	Refills
Cellcept®	200mg/ml 250mg 500mg				
Gengraf (Modified Cyclosporine)	25mg 50mg 100mg				
Myfortic® (Mycophenolic Acid)	180mg 360mg				
Neoral®(Modified Cyclosporine)	25mg 100mg 100mg/ml				
Prograf®	0.5mg 1mg 5mg				
Rapamune® (Sirolimus)	0.5mg 1mg 2mg 1mg/ml				
Sandimmune (Non-Modified Cyclosporine)	25mg 100mg				
Tacrolimus (Compounded Tacrolimus Liquid)	0.5mg/1ml 1mg/1ml				
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 Permissable _____ 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.
*Fax does not constitute a valid prescription as per NY State Board of Pharmacy.

# of Prescriptions: _____