LeMed
SPECIALTY PHARMACY

ORGAN TRANSPLANT

2417 3rd Ave, Ste 406
Bronx, NY 10451
Phone: 347-913-4656
Fax: 718-231-2727

Patient Information - Please send demographic sheet and a copy of the patient's insurance cards

Patient Name:	Date of Birth:	Male Female	
Address:	City:	State:	Zip:
Mobile Phone:	Home Phone:	Language:	
Allergies **(Required):** NKDA	Height: Weight:	SSN:	

Medication Delivery Options: Patient's Home Hospital/Clinic Office Bedside **Delivery Address:**

Prescriber Information

Practice Name:	Office Contact:		
Prescriber:	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information - Please send all available chart notes including lab results

ICD-10:	**Date of Transplant:**	**Date of Discharge:**

Therapies tried and failed with length of treatments:

Check	Medication Name	Strength	Dose/Frequency
	Asprin	81 mg	Take 1 tablet daily
	Atovaquone suspension	750 mg/5 ml	Take 1500 mg daily
	Bactrim	SS DS	
	Calcium/Vitamin D	500 mg/ 200 iu	Take 1 tablet twice daily
	Clotrimazole Troche	10 mg	Take 1 tablet every 8 hours
	Docusate	100 mg	Take 1 capsule three times daily
	Ferrous Gluconate	324 mg	Take 1 tablet twice daily
	Glucometer/Lancets/Strips	81 mg	Testing up to ( ) times daily
	Lantus (or covered product)	81 mg	Inject ( ) units SC at bedtime
	Magnesium Oxide	400 mg	Take 1 tablet twice daily
	Multivitamin	81 mg	Take 1 tablet daily
	MycophenoLIC	180 mg 360 mg	
	MycophenoLATE	250 mg 500 mg	
	Novolog (or covered product)		Inject ( ) units SC three times daily
	Novolin NPH vials		Inject ( ) units SC ( ) daily
	Nystatin suspension	100,000 u/ml	Swish and swallow 5 ml every 6 hours
	Pen needles	( ) mm	
	Prednisone	5 mg	Take 4 tablets daily
	Senna	8.6 mg	Take 2 tablets every night at bedtime (as needed)
	Tacrolimus	0.5 mg	Take 1 capsule every 12 hours
	Tacrolimus	1 mg	Take 4 capsules every 12 hours
	Ursodiol	300 mg	
	Valcyte	450 mg	

Transplant Team Contact

Phone

Email

Delivery Contact Person

Delivery Contact Phone

Delivery Location

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize LeMed Specialty Pharmacy and/or its affiliate pharmacies to facilitate benefits investigations, complete and submit prior authorization (PA) requests, appeals, step edits and other processes necessary to obtain coverage for prescribed medications, to sign any necessary forms on my behalf of my patients, and to attach its Enrollment Form to the PA request as my signature.

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***Fax does not constitute a valid prescription as per NYS Board of Pharmacy. Please electronically prescribe order.**

Prescriber Signature: ______________________ **Date:** ____________