

**TRANSPLANT  
ENROLLMENT / PRESCRIPTION FORM**  
Customer Service Phone 1-800-850-9122 Fax to 1-800-218-3221

**PATIENT INFORMATION**

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Date of Birth / /			
Shipping Address (if different from home address) <input type="checkbox"/> Ship to MD		Home Phone Number	Work Phone Number

**INSURANCE INFORMATION** (fill out entirely or fax a copy of patient's Insurance card, both sides)

<b>Primary Insurance</b>	<b>Secondary Insurance</b>
Policy Number	Policy Number
Group Number	Group Number

**MEDICAL INFORMATION**

Organ Transplanted:  Kidney  Lung  Pancreas  Liver  other (specify) \_\_\_\_\_ Donor Type  Living  Cadaver  
 Date of Transplant: \_\_\_\_\_ Discharge Date: \_\_\_\_\_ Start Date of therapy: \_\_\_\_\_  
 Transplant Facility: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  NKDA  
 Current Medications: \_\_\_\_\_  See Attached  
 Co-Morbidities: \_\_\_\_\_  See Attached

**PRESCRIPTION INFORMATION**

**"Generic will be substituted unless BNMN/DAW box is checked"**

<input type="checkbox"/> <b>CellCept</b> <input type="checkbox"/> 250mg Capsule <input type="checkbox"/> 500mg Tablet <input type="checkbox"/> 200mg/ml Suspension <input type="checkbox"/> <b>Directions:</b> Quantity: _____ Refill x: _____ <input type="checkbox"/> BNMN/DAW	<input type="checkbox"/> <b>Myfortic</b> <input type="checkbox"/> 180mg Tablet <input type="checkbox"/> 360mg Tablet <input type="checkbox"/> <b>Directions:</b> Quantity: _____ Refill x: _____ <input type="checkbox"/> BNMN/DAW
<input type="checkbox"/> <b>Neoral</b> <input type="checkbox"/> 25mg Capsule <input type="checkbox"/> 100mg Capsule <input type="checkbox"/> 100mg/ml Solution <input type="checkbox"/> <b>Directions:</b> Quantity: _____ Refill x: _____ <input type="checkbox"/> BNMN/DAW	<input type="checkbox"/> <b>Prograf</b> <input type="checkbox"/> 0.5mg Capsule <input type="checkbox"/> 1mg Capsule <input type="checkbox"/> 5mg Capsule <input type="checkbox"/> <b>Directions:</b> Quantity: _____ Refill x: _____ <input type="checkbox"/> BNMN/DAW
<input type="checkbox"/> <b>Sandimmune</b> <input type="checkbox"/> 25mg Capsule <input type="checkbox"/> 100mg Capsule <input type="checkbox"/> 100mg/ml Solution <input type="checkbox"/> <b>Directions:</b> Quantity: _____ Refill x: _____ <input type="checkbox"/> BNMN/DAW	<input type="checkbox"/> <b>Rapamune</b> <input type="checkbox"/> 1mg Tablet <input type="checkbox"/> 2mg Tablet <input type="checkbox"/> 1mg/ml Solution <input type="checkbox"/> <b>Directions:</b> Quantity: _____ Refill x: _____ <input type="checkbox"/> BNMN/DAW
<input type="checkbox"/> <b>Zortress</b> <input type="checkbox"/> 0.25mg Tablet <input type="checkbox"/> 0.50mg Tablet <input type="checkbox"/> 0.75mg Tablet <input type="checkbox"/> <b>Directions:</b> Quantity: _____ Refill x: _____ <input type="checkbox"/> BNMN/DAW	<input type="checkbox"/> <b>Other:</b> <input type="checkbox"/> <b>Directions:</b> Quantity: _____ Refill x: _____ <input type="checkbox"/> BNMN/DAW

**PRESCRIBER INFORMATION**

Prescriber Name	Specialty	Office Contact	Phone Number
Address	City	State	Zip
Fax Number			
Today's Date / /	Date Needed By / /	DEA <input type="checkbox"/> On File	NPI <input type="checkbox"/> On File

I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.

Prescriber's Signature

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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