@pfsprx #pfsprx

VERBAL ORDER FORM
TRANSPLANT

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NPI# 1669881777 NABP# 3148839
info@pfsprx.com PFSPrx.com

Today's Date ______________
Date Needed ______________

Specialty Pharmacy Expires 07/01/2023

Rare Disease Pharmacy Center of Excellence Expires 07/01/2023

☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
Ship to: ☐ Physician Office
☐ Nurse / Training
☐ PFSP Pharmacy

Patient Name______________________ Date of Birth__________ ☐ Male ☐ Female
Address______________________ Apt #______ City______________ State_____ Zip________
Telephone______________ Cell______________ SSN______________ Email______________
Allergies______________________ Comorbidities______________________
Current Medications (if necessary, please fax a complete list)______________________

Primary Insurance______________________ ID#______________ Group #______________
Insured's Name______________________ Employer______________________
City______________ State________ Phone______________

ICD-10 Diagnosis Code: ☐ Heart (Z94.1) ☐ Liver (Z94.4) ☐ Pancreas (Z94.83) ☐ Kidney (Z94.0) ☐ Lung (Z94.2)
☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Peripheral Stem Cells (Z94.84) ☐ Other specified organ or tissue (Z94.89) __________
Date of Diagnosis __________ Date of Transplant __________ Date of Discharge __________ Est. Discharge Time __________
Was there a prior transplant failure of the same organ? ☐Yes ☐ No
Allergies ______________________

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

IMMUNOSUPPRESSANTS

☐ **PROGRAF® (tacrolimus)**
☐ 0.5mg ☐ 1mg ☐ 5mg
QTY _____ Refill _______
SIG ______________________

☐ **NEORAL® (cyclosporine)**
☐ 25mg ☐ 100mg
QTY_____ Refill _______
SIG ______________________

☐ **PREDNISONE®**
☐ 5mg
QTY _____ Refill _______
SIG ______________________

☐ **RAPAMUNE® (sirolimus)**
☐ 1mg ☐ 2mg
QTY _____ Refill _______
SIG ______________________

☐ **CELLCEPT® (mycophenolate)**
☐ 250mg ☐ 500mg
QTY_____ Refill _______
SIG ______________________

☐ **OTHER** ______________
Strength __________
QTY _____ Refill _______
SIG ______________________

☐ **GENGRAF® (cyclosporine)**
☐ 25mg ☐ 100mg
QTY _____ Refill _______
SIG ______________________

☐ **MYFORTIC® (mycophenolic acid)**
☐ 180mg ☐ 360mg
QTY _____ Refill _______
SIG ______________________

☐ **OTHER** ______________
Strength __________
QTY _____ Refill _______
SIG ______________________

☐ **PCP PROPHYLAXIS** ☐ **THRUSH (CANDIDA)** ☐ **ANTIHYPERTENSIVES**
☐ **CMV PROPHYLAXIS** ☐ **GASTROINTESTINAL** ☐ **HEMATOPOIETICS**
Strength ______________ QTY________ Refill ________ SIG ______________

DIABETIC SUPPLIES

Is patient a ☐ Type 1 (insulin-dependent) or ☐ Type 2 (non-insulin dependent) diabetic? ☐ Not a Diabetic

__________ **GLUCOMETER** ☐ **TEST STRIPS** ☐ **LANCETS** ☐ **INSULIN SYRINGES** 0.5cc
☐ **SHORT-ACTING INSULIN** ______________ ☐ **LONG-ACTING INSULIN** ______________

Prescriber's Name / Practice ______________________ Office Contact______________
Address______________________ Suite#______ City______________ State_____ Zip________
Tel______________ Fax______________ Email______________
License#______________ NPI#______________ UPIN#______________ DEA#______________
Prescriber's Signature (signature required. NO STAMPS)______________________ **Date**__________

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