

Transplant Referral Form



Phone: 808-533-8887
 Fax: 808-533-1888
 E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: Patient Physician

Patient	Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address: _____ City: _____ State: _____ Zip: _____
	Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
	Comorbidities: _____ Height: _____ Weight: _____ Date: _____
	Allergies: _____ <input type="checkbox"/> NKDA

Provider	Physician Name: _____ Practice Name: _____ State Lic#: _____ DEA#: _____
	Address: _____ City: _____ State: _____ Zip: _____ NPI#: _____
	Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance	Primary Insurance: _____ ID: _____ Phone: _____
	Secondary Insurance: _____ ID: _____ Phone: _____
	* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info	<u>Medical Necessity</u>	<u>Additional Information</u>
	<input type="checkbox"/> Heart (Z94.1) <input type="checkbox"/> Liver (Z94.4)	Transplant date: ____/____/____
	<input type="checkbox"/> Kidney (Z94.0) <input type="checkbox"/> Bone Marrow (Z94.81)	Was there a prior transplant failure of the same organ? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Pancreas (Z94.83) <input type="checkbox"/> Lung (Z94.2)	Did patient have Medicare A coverage at time of transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Intestines (Z94.82) <input type="checkbox"/> Peripheral Stem Cells (Z94.84)	Will patient be enrolled in Medicare B at time of discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Other: _____ ICD-10 _____	Comments _____

Prescription

Medication	Strength	Directions	Quantity	Refill
<input type="checkbox"/> Cellcept [®] (Mycophenolate Mofetil)*	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg			
<input type="checkbox"/> Prograf [®] (Tacrolimus)*	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 5 mg			
<input type="checkbox"/> Neoral [®] (Cyclosporine Modified)	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg			
<input type="checkbox"/> Rapamune [®] (Sirolimus)	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg			
<input type="checkbox"/> Imuran [®] (Azathioprine)	<input type="checkbox"/> 50 mg			
<input type="checkbox"/> Myfortic [®] (Mycophenolic Acid EC)	<input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg			
<input type="checkbox"/> Valcyte [®] (Valganciclovir)	<input type="checkbox"/> 450 mg			
<input type="checkbox"/> Mycelex [®] (Clotrimazole troches)	<input type="checkbox"/> 10 mg			
<input type="checkbox"/> Diflucan [®] (Fluconazole)	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg			
<input type="checkbox"/> Bactrim [™] / Septra [®] (SMZ/TMP)	<input type="checkbox"/> SS <input type="checkbox"/> DS			
<input type="checkbox"/> Nystatin suspension	100,000U/ML			
<input type="checkbox"/> Prednisone	<input type="checkbox"/> 1 mg <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg			
<input type="checkbox"/> Other Medications:				

Physicians Signature: _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

In compliance with applicable state regulations and most insurer policies, The Honolulu Pharmacy will dispense available FDA-approved generic equivalents, unless physician wrote "Brand Medical Necessary".

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