Transplant Referral Form

THE HONOLULU PHARMACY
COMPOUNDING PHARMACY & SPECIALTY PHARMACY

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: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Work #: _____ Cell#: _____ Best time to call: ☐ AM ☐ PM
Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
Comorbidities: _____ Height: _____ Weight: _____ Date: _____
Allergies: _____ ☐ 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

Medical Necessity

☐ Heart (Z94.1) ☐ Liver (Z94.4)
☐ Kidney (Z94.0) ☐ Bone Marrow (Z94.81)
☐ Pancreas (Z94.83) ☐ Lung (Z94.2)
☐ Intestines (Z94.82) ☐ Peripheral Stem Cells (Z94.84)
☐ Other: _____ ICD-10 _____

Additional Information

Transplant date: _____/_____/_____
Was there a prior transplant failure of the same organ? ☐ Yes ☐ No
Did patient have Medicare A coverage at time of transplant? ☐ Yes ☐ No
Will patient be enrolled in Medicare B at time of discharge? ☐ Yes ☐ No
Comments _____

Prescription

Medication	Strength	Directions	Quantity	Refill
☐ **Cellcept®** (Mycophenolate Mofetil)*	☐ 250 mg ☐ 500 mg			
☐ **Prograf®** (Tacrolimus)*	☐ 0.5 mg ☐ 1 mg ☐ 5 mg			
☐ **Neoral®** (Cyclosporine Modified)	☐ 25 mg ☐ 100 mg			
☐ **Rapamune®** (Sirolimus)	☐ 0.5 mg ☐ 1 mg ☐ 2 mg			
☐ **Imuran®** (Azathioprine)	☐ 50 mg			
☐ **Myfortic®** (Mycophenolic Acid EC)	☐ 180 mg ☐ 360 mg			
☐ **Valcyte®** (Valganciclovir)	☐ 450 mg			
☐ **Mycelex®** (Clotrimazole troches)	☐ 10 mg			
☐ **Diflucan®** (Fluconozole)	☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg			
☐ **Bactrim™ / Septra®** (SMZ/TMP)	☐ SS ☐ DS			
☐ **Nystatin suspension**	100,0000U/ML			
☐ **Prednisone**	☐ 1 mg ☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 20 mg			
☐ **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".