TRANSPLANT Prescription Referral Form

4915 BRAODWAY, NEW YORK, NY 10034, TEL: 212-304-4646
FAX: 212-304-0759, Toll Free Number: 1-844-295-8203,
Email: inwoodpharma@gmail.com, Web: www.inwoodpharmacy.com

PATIENT INFORMATION

Patients Name :	SSN#:	DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male Female
Email Address:	Diagnosis Code:

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxID:	Phone:
Secondary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxID:	Phone:

DIAGNOSIS/CLINICAL INFORMATION [*Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization]*

Transplant Date: ________________________ Anticipated Discharge Date: ________________________

Organ Transplanted (choose one): ☐ Heart ☐ Lung ☐ Kidney ☐ Pancreas Liver

PRESCRIPTION INFORMATION

MEDICATION	DOSE / STRENGTH	MAX. DAILY DOSAGE	SIG	QTY	REFILLS
PROGRAF	☐ 0.5mg ☐ 1mg ☐ 5mg				
TACROLIMUS (Compounded Tacrolimus Liquid)	☐ 0.5mg/1ml ☐ 1mg/1ml				
RAPAMUNE (Sirolimus)	☐ 0.5mg ☐ 1mg ☐ 2mg ☐ 1mg/ml				
NEORAL	☐ 25mg ☐ 100mg ☐ 100mg/ml				
MYFORTIC (Mycophenolic Acid)	☐ 180mg ☐ 360mg				
CELLCEPT	☐ 200mg/ml ☐ 250mg ☐ 500mg.				
VALCYTE (Valganciclovir)	☐ 450mg ☐ 50mg/ml				
VFEND	☐ 50mg ☐ 200mg ☐ 40mg/ml				
ZORTRESS	☐ 0.25mg ☐ 0.5mg ☐ 0.75mg				
HECORIA	☐ 0.5mg ☐ 1mg ☐ 5mg				
Transplant Kit (BP monitor, therm., pill cutter, pill box, blood pressure cuff) Cuff Size: ☐ S ☐ M ☐ L	1 package	Use as directed		1	

Prescriber Name:	Phone:	Fax:
Office Address:	Email:	NPI#:
DEA#:	LIC#:	☐ Dispense as written:	Date
Prescriber Signature :	Deliver To : ☐ M D Office ☐ Patient Home

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed Medications. We will also pursue available copay and financial assistance on behalf of your patients.