ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

TRANSPLANT REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Date:_____
☐ NEW PATIENT
☐ CURRENT PATIENT

URAC ACCREDITED Specialty Pharmacy

Patient Name First Name Middle Name Last Name DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

Diagnosis ☐ Heart ICD-10 ☐ Liver ICD-10 ☐ Pancreas ICD-10 ☐ Kidney ICD-10 ☐ Bone Marrow ICD-10 ☐ Intestines ICD-10 ☐ Lung ICD-10 ☐ Peripheral Stem Cells ICD-10

Other specified organ or tissue ICD-10 _____ Date of Diagnosis _____ Date of Transplant _____ Date of Discharge _____ Est. Discharge Time _____

Was there a prior transplant failure of the same organ? ☐ Yes ☐ No Does patient have Medicare Part A coverage at time of transplant? ☐ Yes ☐ No

Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary. ☐ Yes ☐ No *Agency of choice: _____

Date training occurred _____ ☐ Injection training not necessary Reason: ☐ MD office trained patient ☐ Patient already independent ☐ Referred to alternate trainer

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

IMMUNOSUPPRESSANTS

PROGRAF (tacrolimus) 0.5mg 1mg 5mg
QTY ____ Refill x ____ Sig ____

RAPAMUNE (sirolimus) 1mg 2mg
QTY ____ Refill x ____ Sig ____

GENGRAF (cyclosporine) 25mg 100mg
QTY ____ Refill x ____ Sig ____

NEORAL (cyclosporine) 25mg 100mg
QTY ____ Refill x ____ Sig ____

CELLCEPT (mycophenolate) 250mg 500mg
QTY ____ Refill x ____ Sig ____

MYFORTIC (mycophenolic acid) 180mg 360mg
QTY ____ Refill x ____ Sig ____

PREDNISONE 5mg
QTY ____ Refill x ____ Sig ____

OTHER _____
QTY ____ Refill x ____ Sig ____

OTHER _____
QTY ____ Refill x ____ Sig ____

OTHER _____
QTY ____ Refill x ____ Sig ____

PCP PROPHYLAXIS _____ Strength ____ QTY ____ Refill x ____ Sig ____

CMV PROPHYLAXIS _____ Strength ____ QTY ____ Refill x ____ Sig ____

THRUSH (candida) _____ Strength ____ QTY ____ Refill x ____ Sig ____

_____ Strength ____ QTY ____ Refill x ____ Sig ____

GASTROINTESTINAL _____ Strength ____ QTY ____ Refill x ____ Sig ____

ANTIHYPERTENSIVES _____ Strength ____ QTY ____ Refill x ____ Sig ____

_____ Strength ____ QTY ____ Refill x ____ Sig ____

_____ Strength ____ QTY ____ Refill x ____ Sig ____

HEMATOPOIETICS _____ Strength ____ QTY ____ Refill x ____ Sig ____

_____ Strength ____ QTY ____ Refill x ____ Sig ____

DIABETIC SUPPLIES Is patient a type 1 (insulin-dependent) or type 2 (non-insulin dependent) diabetic? _____ Type 1 _____ Type 2 _____ Not a Diabetic

_____ **GLUCOMETER** QTY ____ Refill x ____ Sig ____ **TEST STRIPS** QTY ____ Refill x ____ Sig ____ **LANCETS** QTY ____ Refill x ____ Sig ____

INSULIN SYRINGES 0.5cc QTY ____ Refill x ____ Sig ____ **SHORT-ACTING INSULIN** _____ **LONG-ACTING INSULIN** _____

Any known allergies? ____ Yes ____ No
List _____

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____