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

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

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 (V42.1) ☐ Liver (V42.7) ☐ Pancreas (V42.83) ☐ Kidney (V42.0) ☐ Bone Marrow (42.81) ☐ Intestines (V42.84) ☐ Lung (V42.6) ☐ Peripheral Stem Cells (42.82)

Other specified organ or tissue (42.89) Date of Diagnosis Date of Transplant Date of Discharge Est. Discharge Time

Was there a prior transplant failure of the same organ? ☐ Yes ☐ No 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**

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Please fax completed form to St. Jude at 718-417-3621

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