Transplant Referral Form

Date:_____

Evolutionary Pharmacy Solutions

13619 Inwood Rd, Ste 380, Dallas, Texas, 75244

Phone: 1-844-800-5377 **Fax: 1-800-239-0363**

EPSRX

PATIENT INFORMATION:

Patient Name: _____
Address: _____
City, State, Zip: _____
Cell Phone: _____
Home Phone: _____ Language: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Guardian/Caregiver & Number: _____

PRESCRIBER INFORMATION:

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA: _____ NPI: _____
Office Contact: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card if available)

Insurance Name: _____ ID Number: _____ Group: _____

CLINICAL INFORMATION

DIAGNOSIS: ICD-10 _____

Date of Transplant: _____

TYPE: ☐ Heart ☐ Lung ☐ Pancreas ☐ Kidney ☐ Liver

MEDICAL CONDITIONS:

☐ Hypertension ☐ Diabetes ☐ ESRD

Other: _____

Weight (kg): _____ Height (cm) _____ **Therapy** ☐ New ☐ Reauthorization ☐ Restart

SCr/CrCl _____ WNL: ☐ Yes ☐ No LFTs _____ WNL: ☐ Yes ☐ No

☐ Dialysis (type): _____ Schedule: _____

Blood Type: _____ **Prior Therapies:** _____

Tx Response/Dates: _____

Allergies: _____

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Astagraf XL** (Tacrolimus)	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ **Azasan** (Azathioprine)	☐ 75mg ☐ 100mg			
☐ **Cellcept** (Mycophenolic mofetil)	☐ 250mg ☐ 500mg ☐ 200mg/ml			
☐ **Envarsus XR** (Tacrolimus)	☐ 0.75mg ☐ 1mg ☐ 4mg			
☐ **Gengraf** (Cyclosporine modified)	☐ 25mg ☐ 100mg ☐ 100mg/ml			
☐ **Imuran** (Azathioprine)	☐ 50mg			
☐ **Myfortic** (Mycophenolic acid)	☐ 180mg ☐ 360mg			
☐ **Neoral** (Cyclosporine modified)	☐ 25mg ☐ 100mg ☐ 100mg/ml			
☐ **Prograf** (Tacrolimus)	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ **Rapamune** (Sirolimus)	☐ 0.5mg ☐ 1mg ☐ 2mg ☐ 1mg/ml			
☐ **Sandimmune** (Cyclosporine non-modified)	☐ 25mg ☐ 100mg ☐ 100mg/ml			
☐ **Zortress** (Everolimus)	☐ 0.25mg ☐ 0.50mg ☐ 0.75mg			
☐ **Bactrim** (SMZ/TMP)	☐ 800/160mg (DS) ☐ 400/80mg (SS)			
☐ **Clotrimazole**	☐ 10mg Troches			
☐ **Furosmide**	☐ 20mg ☐ 40mg			
☐ **Lidocaine 5% Patch**	☐ 700mg/patch 5%			
☐ **Prednisone**				
☐ **Protonix** (Pantoprazole)	☐ 20mg ☐ 40mg			
☐ **Valcyte** (Valganciclovir)	☐ 450mg ☐ 50mg/ml			
☐ **Vfend** (Voriconazole)	☐ 50mg ☐ 200mg ☐ 40mg/ml			
☐ **Other:**				
☐ **Other:**				

☐ **Equipment**: _____ ☐ Transplant Kit (BP Monitor & Cuff, Thermometer, Pill Cutter & Box) Cuff Size: _____ ☐ Scale

Prescriber Signature: Stamp signature not allowed, physician signature required

Verbal Readback ☐ Yes ☐ No

X_____ X_____ Date: _____

Dispense as written Product substitution permitted