

# BERGEN AVE DRUGS

## Specialty Pharmacy

# TRANSPLANT REFERRAL FORM

745 Bergen Ave | Jersey City, NJ, 07306

Tel 201.521.0545 | Fax 201.521.0546

Today's Date

NEW PATIENT  CURRENT PATIENT

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Last updated: May 2017

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 (Z94.1)  Liver (Z94.4)  Pancreas (Z94.83)  Kidney (Z94.0)  Bone Marrow (Z94.81)  Intestines (Z94.82)  Lung (Z94.2)  Peripheral Stem Cells (Z94.84)

Other specified organ or tissue (Z94.89) \_\_\_\_\_ 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

<b>PROGRAF (tacrolimus)</b> 0.5mg 1mg 5mg QTY _____ Refill x _____ Sig _____	<b>MYFORTIC (mycophenolic acid)</b> 180mg 360mg QTY _____ Refill x _____ Sig _____
<b>RAPAMUNE (sirolimus)</b> 1mg 2mg QTY _____ Refill x _____ Sig _____	<b>PREDNISONE</b> 5mg QTY _____ Refill x _____ Sig _____
<b>GENGRAF (cyclosporine)</b> 25mg 100mg QTY _____ Refill x _____ Sig _____	<b>OTHER</b> _____ QTY _____ Refill x _____ Sig _____
<b>NEORAL (cyclosporine)</b> 25mg 100mg QTY _____ Refill x _____ Sig _____	<b>OTHER</b> _____ QTY _____ Refill x _____ Sig _____
<b>CELLCEPT (mycophenolate)</b> 250mg 500mg QTY _____ Refill x _____ Sig _____	<b>OTHER</b> _____ QTY _____ Refill x _____ Sig _____

### ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

<b>PCP PROPHYLAXIS</b> _____ Strength _____ QTY _____ Refill x _____ Sig _____
<b>CMV PROPHYLAXIS</b> _____ Strength _____ QTY _____ Refill x _____ Sig _____
<b>THRUSH (candida)</b> _____ Strength _____ QTY _____ Refill x _____ Sig _____
_____ Strength _____ QTY _____ Refill x _____ Sig _____
<b>GASTROINTESTINAL</b> _____ Strength _____ QTY _____ Refill x _____ Sig _____
<b>ANTIHYPERTENSIVES</b> _____ Strength _____ QTY _____ Refill x _____ Sig _____
_____ Strength _____ QTY _____ Refill x _____ Sig _____
_____ Strength _____ QTY _____ Refill x _____ Sig _____
<b>HEMATOPOIETICS</b> _____ 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

Any known allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No

**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** \_\_\_\_\_

Prescriber's Signature (signature required. NO STAMPS) \_\_\_\_\_ Date \_\_\_\_\_

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Please fax completed form to **Bergen** at **201.521.0546**

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