Transplant Enrollment Form

Fax Referral To: 1-718-261-6689
Email Referral To: info@healthycornerpharmacy.com
Phone: 1-855-261-6699

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____Address: _____City, State, ZIP: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____DOB: _____ Gender: ☐ Male ☐ Female
Email: _____Last Four of SSN: _____Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP: _____
Phone: _____ Fax_____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ Z94.0 Kidney Transplant Status ☐ Z94.1 Heart Transplant Status ☐ Z94.2 Lung Transplant Status
☐ Z94.3 Heart and Lung Transplant Status ☐ Z94.4 Liver Transplant Status ☐ Z94.5 Skin Transplant Status
☐ Z94.6 Bone Transplant Status ☐ Z94.7 Corneal Transplant Status ☐ Z94.81 Bone MarrowTransplant Status
☐ Z94.82 Intestine Transplant Status ☐ Z94.83 Pancreas Transplant Status ☐ Z94.84 Stem Cells Transplant Status
☐ Other Code: _____ Description _____
For additional ICD-10 information, please visit www.icd10-data.com

Required Information for Organ Transplant Patients:

Patient Medicare status (check all that apply):
☐ Had Medicare at time of transplant ☐ Currently has Medicare ☐ Does not have Medicare
If patient has Medicare, please provide Medicare ID: _____
Date of Transplant: _____ Discharge Date: _____
Hospital Name, City and State: _____
For Kidney Transplant: Initial Dialysis Date_____ Type of Dialysis ☐ Hemo ☐ Peritoneal

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

5 PRESCRIPTION INFORMATION (DIABETIC SUPPLIES)

☐ Not a Diabetic
☐ Insulin ☐ Non-Insulin Diagnosis Code: _____
Glucometer: _____
Test Strips: _____
Lancets: _____
0.5 cc Insulin Syringes: _____
Short Acting Insulin: _____
Long-Acting Insulin: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)
X_____ X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize Healthy Corner Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Transplant Enrollment Form

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION (IMMUNOSUPPRESSANTS)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Astagraf XL®	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Azasan®	☐ 75 mg ☐ 100 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Cellcept®	☐ 250 mg ☐ 500 mg ☐ 200 mg/mL	☐ Other: _____	Quantity:____ Refills: ____
☐ Envarsus XR®	☐ 0.75 mg ☐ 1 mg ☐ 4 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Gengraf®	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	☐ Other: _____	Quantity:____ Refills: ____
☐ Imuran®	50 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Myfortic®	☐ 180 mg ☐ 360 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Neoral®	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	☐ Other: _____	Quantity:____ Refills: ____
☐ Prednisone	☐ 5 mg ☐ 10 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Prograf®	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Rapamune®	☐ 0.5 mg ☐ 1 mg ☐ 2 mg ☐ 1 mg/mL	☐ Other: _____	Quantity:____ Refills: ____
☐ Sandimmune®	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	☐ Other: _____	Quantity:____ Refills: ____
☐ Zortress®	☐ 0.25 mg ☐ 0.50 mg ☐ 0.75 mg	☐ Other: _____	Quantity:____ Refills: ____

5 PRESCRIPTION INFORMATION (OTHER)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ PCP Prophylaxis: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ PCP Prophylaxis: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ CMV Prophylaxis: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ CMV Prophylaxis: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ Thrush (Candida): _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ Hematopoietics: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ Hematopoietics: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ Gastrointestinal: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ Gastrointestinal: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____
☐ Gastrointestinal: _____	Other: _____	☐ Other: _____	Quantity:____ Refills: ____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

☐ Other: _____ Other: _____ ☐ Other: _____ Quantity:____ Refills: ____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

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