Transplant Enrollment Form

Phone: 800-361-1260
Fax: 800-737-4920

CORNERSTONE PHARMACY

PATIENT INFORMATION (PLEASE PRINT)

Patient Name (Last, First, Mi)			☐ Male ☐ Female	
Date of Birth (mm/dd/yyyy)	SS#	Phone (Daytime)	Phone (Evening)	
Street Address (Please include Suite/Apt Number)		City	State	Zip
Patient Co-pay method: ☐ Credit Card ☐ Check	Card Type: ☐ MC ☐ VISA	Card Number:_____________________		Exp:___/_____

INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT'S PHARMACY BENEFIT CARD - FRONT AND BACK)

Primary Insurance		Policy Holder
Policy #	Group #	Phone

DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)

☐ Heart - V421 ☐ Kidney – V420 ☐ Pancreas – V4283 ☐ Intestines – V4284 ☐ Liver – V427 ☐ Bone Marrow – V4281 ☐ Lung – V426
☐ Peripheral Stem Cells – V4282 ☐ Other:______________________ICD-9:_____________

Transplant date:_____/_____/_________ Comments:____
Was there a prior transplant failure of the same organ? ☐ Yes ☐ No
Did patient have Medicare A coverage at time of transplant? ☐ Yes ☐ No
Will patient be enrolled in Medicare B at time of discharge? ☐ Yes ☐ No
Patient Weight: __________ lbs. OR ___________ kg. Drug Allergies: __________________________ ☐ NKDA

PRESCRIPTION INFORMATION

Rx-Medication	*Strength*	*Dose and Frequency*	*Quantity*	*Refills*
☐ Prograf® (tacrolimus)	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ Rapamune® (sirolimus)	☐ 1mg ☐ 2mg			
☐ Gengraf ® (cyclosporine)	☐ 25mg ☐ 100mg			
☐ Neoral® (cyclosporine)	☐ 25mg ☐ 100mg			
☐ Cellcept® (mycophenolate)	☐ 250mg ☐ 500mg			
☐ Myfortic® (mycophenolic acid)	☐ 180mg ☐ 360mg			
☐ Valcyte® (Valganciclovir)	☐ 450 mg			
☐ Prednisone	☐ 5 mg			
☐ Other _______________				
☐ Other _______________				
☐ Other _______________				

DELIVERY INFORMATION

☐ Patient's Home	☐ Physician's Office	Date Needed:	Patient needs Education Kit? ☐ yes ☐ no
Teaching to be done at:	☐ Patient's Home ☐ Physician's Office ☐ Not needed		

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION

Physician Name	License #	DEA #	UPIN #
Office Contact	Phone	Fax	NPI#
Street Address (Please include Suite Number)		City/State/Zip	
Physician's Signature		Date (required)	

This prescription will be filled generically unless Prescriber writes "DAW" in the box to the right. ☐