benevere PHARMACY
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beneverepharmacy.com

TODAY'S DATE:_____

☐ NEW PATIENT ☐ CURRENT PATIENT

Transplant Referral Form

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State_____ Zip_____

Home Phone_____ Cell_____

DOB_____ SSN_____

Drug Allergies_____ ☐ Male ☐ Female

Patient Weight: _____ Height: _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____

NPI# _____ Tax ID_____

Practice Name _____

Address_____ Suite_____

City _____ State_____ Zip_____

Office Phone_____ Fax_____

Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____

Policy # _____ Group_____

Insurance Phone_____

Prescription Drug Coverage: Company_____

RXGRP#_____ RXBIN#_____ PCN/ID# *(if available)*_____

Secondary Insurance (if applicable)_____

Policy # _____ Group_____

Insurance Phone_____

Phone_____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis: ☐ V42.1 Heart ☐ V42.7 Liver ☐ V42.6 Lung ☐ V42.0 Kidney ☐ V42.83 Pancreas ☐ Other _____

Transplant Date: _____ Donor: ☐ Cadaveric ☐ Living Primary Disease: _____

Post-Transplant prophylaxis of primary disease, if applicable: _____

Post-Transplant complications (date/treatment): ☐ AR _____ ☐ CR _____ ☐ Post-Transplant Infections _____

☐ PTDM: _____ ☐ Other _____ Scr _____ mg/dL

DRUG NAME	DOSE	DIRECTIONS FOR USE	QTY	REFILLS
☐ Prograf® (Tacrolimus)	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ Hecoria® (Tacrolimus)	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ Neoral® (Cyclosporine, modified)	☐ 25mg ☐ 100mg			
☐ Gengraf® (Cyclosporine, modified)	☐ 25mg ☐ 100mg			
☐ Rapamune® (Sirolimus)	☐ 0.5mg ☐ 1mg ☐ 2mg			
☐ Zortress® (Everolimus)	☐ 0.25mg ☐ 0.5mg ☐ 0.75mg			
☐ Cellcept® (Mycophenolate Mofalil)	☐ 250mg ☐ 500mg			
☐ Myfortic® (Mycophenclic Acid EC)	☐ 180mg ☐ 360mg			
☐ Prednisone				

Form continued on next page

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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

PATIENT NAME: _____ DOB: _____ **Transplant Referral Form** *(continued from last page)*

DRUG NAME	DOSE	DIRECTIONS FOR USE	QTY	REFILLS
☐ Diflucan® (Fluconozle)	☐ 100mg ☐ 200mg			
☐ Sporanox® (Itraconazole)	☐ 100mg			
☐ Vfend® (Voriconazole)	☐ 50mg ☐ 200mg			
Amphotericin B ☐ Conventional ☐ Liposomal				
☐ Nystatin suspension	100,000 OU/ML			
☐ Zovirax® (Acyclovir)	☐ 200mg ☐ 400mg ☐ 800mg			
☐ Valcyte® (Valgancyclovir)	☐ 450mg			
☐ Bactrim™/Septra® (SMZ/TMP)	☐ SS ☐ DS			
☐ Baraclude® (Entecavir)	☐ 0.5mg ☐ 1mg			
☐ Epivir® (Lamivudine)	☐ 50mg ☐ 100mg ☐ 150mg ☐ 300mg			
☐ Hepsera® (Adefovir)	☐ 10mg	Take one 10mg tablet every _____ hours with or without food		
☐ Viread® (Tenofovir)	☐ 300mg	Take one 300mg tablet every _____ hours with or without food		
☐ Sovaldi® (Simeprevir)	☐ 400mg tablet	Take one 400mg tablet daily with or without food		
☐ Olysio® (Sofosbuvir)	☐ 150mg capsule	Take one 150mg capsule daily with food		
☐ Ribavirin®	☐ 200mg Tablets ☐ 200mg Capsules			

Supplies

Supplies Needed: ☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ Other _____

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

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