Transplant REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 PHONE: +1(844) 650-5802

IV Solutions RX

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

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE

Address: _____ **City/State/Zip:** _____

Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____

Primary RX Insurance:_____ **ID No:**_____ **RX GRP:**_____ **RX BIN:**_____ **RX PCN:**_____

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10):

☐ Z94.0 Kidney Transplant Status ☐ Z94.0 Kidney 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 Marrow Transplant Status ☐ Z94.82 Intestine Transplant Status ☐ Z94.83 Pancreas Transplant Status

☐ Z94.84 Stem Cells Transplant Status ☐ Other Code: _____ Description _____

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:

Drug Allergies:_____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

4 PRESCRIPTION INFORMATION

MEDICATION	STREGNTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
☐ Astagraf XL	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	Other: _____	_____	_____
☐ Astagraf XL	☐ 75 mg ☐ 100 mg	Other: _____	_____	_____
☐ Cellcept	☐ 75 mg ☐ 250 mg ☐ 500 mg ☐ 200 mg/mL	Other: _____	_____	_____
☐ Envarsus XR	☐ 0.75 mg ☐ 1 mg ☐ 4 mg	Other: _____	_____	_____
☐ Gengraf	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: _____	_____	_____
☐ Imuran	☐ 50 mg	Other: _____	_____	_____
☐ Myfortic	☐ 180 mg ☐ 360 mg	Other: _____	_____	_____
☐ Neoral	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: _____	_____	_____
☐ Nulojix	☐ 250 mg vial	Other: _____	_____	_____
☐ Prednisone	☐ 5 mg ☐ 10 mg	Other: _____	_____	_____
☐ Prograf	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	Other: _____	_____	_____
☐ Rapamune	☐ 0.5 mg ☐ 1 mg ☐ 2 mg ☐ 1 mg/mL	Other: _____	_____	_____
☐ Sandimmune	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: _____	_____	_____
☐ Zortress	☐ 0.25 mg ☐ 0.50 mg ☐ 0.75 mg	Other: _____	_____	_____
☐ OTHER: _____	Other: _____	Other: _____	_____	_____

5 PRESCRIBER SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Fax:** _____ **Contact Person:** _____

☐ DISPENSE AS WRITTEN ☐ BRAND MEDICALLY NECESSARY ☐ DO NOT SUBSTITUTE ☐ NO SUBSTITUTION / ☐ DAW / ☐ MAY NOT SUBSTITUTE	☐ May Substitute / ☐ Product Selection Permitted / ☐ Substitution Permissible
Prescriber's Signature: _____ **Date:** _____	**Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to **info@ivsolutionsrx.com** and destroy all copies of the original message.

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE *#welcome to our family*