MAIN POINT OF CONTACT

Name:_____

Phone:_____

ASP CARES
Transplant
Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____

ID#:_____ RxBin:_____ ID#:_____ RxBin:_____

RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Dose/Strength	Directions	Qty	Refills
☐ Prograf	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ Tacrolimus Compounded Tacrolimus Liquid	☐ 0.5mg/1ml ☐ 1mg/1ml			
☐ Rapamune (Sirolimus)	☐ 0.5mg ☐ 1mg ☐ 2mg ☐ 1mg/ml			
☐ Neoral	☐ 25mg ☐ 100mg ☐ 100mg/ml			
☐ Mfortic (Mycophenolic Acid)	☐ 180mg ☐ 360mg			
☐ Cellcept	☐ 200mg/ml ☐ 250mg ☐ 500mg			
☐ Valcyte (Valganciclovir)	☐ 450mg ☐ 50mg/ml			
☐ VFend	☐ 50mg/ml ☐ 200mg ☐ 40mg/ml			
☐ Zortress	☐ 0.25mg ☐ 0.5mg ☐ 0.75mg			
☐ Hecoria	☐ 0.5mg ☐ 1mg ☐ 5mg			

℞

Allergies:

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

***Prescriber Signature:_____ Date:_____**

Please fax completed form to 1 (888) 294-9434