Phone: 1-888-792-1552
Fax: 1-888-216-2510

To ePrescribe send prescription to:
Giant Eagle Pharmacy
20160 Center Ridge Road, Suite 201
Rocky River, OH 44116

TRANSPLANT ENROLLMENT FORM

Today's Date: ____________________

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**______________ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: ______________________ ☐ Male ☐ Female DOB:_______________________
Patient's First Name: _________________________ Patient's Last Name: ___________________________________
Address: _________________________________ City: _____________________ State: _____ ZIP: _____________
Best Phone Number: ____________________________ Alternate Phone Number: __________________________
Height:______________________ Weight: _______________ ☐ kgs. or ☐ lbs. Recorded Date: _________________
Caregiver: _______________________________ Caregiver Contact Number: ____________________________
Allergies: ____
Store Preference (address): ____
Emergency Contact Name: _______________________ Emergency Contact Phone #: _________________________

Insurance Information: Please fax copy of insurance card (front + back)

Primary Insurance: ____ Phone: _____________________________
Policy #: ____ Medicare Effective Date #: ______________________

Clinical Info.

Transplant Date: ____________________________ Anticipated Discharge Date:_________________________
Organ Transplanted: __________________________ Actual Discharge Date: ___________________________

Prescription

Medication	Dose / Strength	SIG	Qty	Refills
☐ Tacrolimus®	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ Mycophenolate Mofetil	☐ 250mg ☐ 500mg ☐ 200mg/ml			
☐ Cyclosporine	☐ 25mg ☐ 100mg			
☐ Myfortic (Mycophenolic acid)	☐ 180mg ☐ 360mg			
☐ Rapamune (Sirolimus)	☐ 0.5mg ☐ 1mg ☐ 2mg ☐ 1mg/ml			
☐ Zortress	☐ 0.25mg ☐ 0.5mg ☐ 0.75mg			
☐ Azathioprine	☐ 50mg			
☐ Prednisone		☐ Taper as directed Other: ______________		
☐ Prednisolone				
☐ Astagraf XL	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ Valcyte™ (Valganciclovir)	☐ 450mg ☐ 50mg/ml			
☐ Acyclovir	☐ 200mg ☐ 400mg ☐ 800mg ☐ 200mg/5ml			
☐ Clotrimazole	☐ 10mg Troches			
☐ Bactrim (Smz/Tmp)	☐ 800mg/160mg (DS) ☐ 400/80mg (SS)			
☐ Protonix (pantoprazole)	☐ 40mg ☐ 20mg			
☐ Lidocaine 5% Patch	☐ 700mg/patch (5%)	Apply____ Patch Daily As Needed		
☐ Furosemide	☐ 20mg ☐ 40mg			
☐ Other				
☐ Other				
☐ Other				

PLEASE WRITE "DAW" NEXT TO MEDICATION NAME IN THE EVENT PRESCRIBER DESIRES BRAND ONLY DISPENSING.

Equipment: _______________ ☐ Transplant Kit (BP Monitor & Cuff, Therm. Pill Cutter & Box) Indicate Cuff Size: (S__) (M__) (L__) ☐ Scale

Prescriber Information

Date Prescription Needed: ____
Physician Name (please print): ___________________________ Contact Name: ______________________
Phone #: ______________________ Fax #:_____________________________ NPI #: ____________________
Office Address: _______________________________ City: ______________ State: ______ ZIP: __________
State License #: ____________________DEA #: ___________________Tax ID #:____________________

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.
____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
Physician Signature: ____ **Date:** ____________________