Avella | briova Rx

Transplant Enrollment Form

Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

Please complete the following or ***send patient demographic sheet***

Patient Name ______

Address ______

Address 2 ______

City, State, ZIP ______

Home Phone ______ Alternate Phone ______

DOB ______ Last Four of SS# ______ Gender ______

Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______

DEA ______

NPI ______

Group / Hospital ______

Address ______

City, State, ZIP ______

Phone ______ Fax ______

Contact Person ______ Phone ______

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number ______

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ ICD-10 ______ Description ______

Transplant Type:

☐ Heart ☐ Kidney ☐ Liver ☐ Lung ☐ Kidney ☐ Pancreas

☐ Other ______

Date of Transplant ______

Test Results: **WNL:**

☐ SCr / CrCl ______ ☐ Yes ☐ No

☐ LFTs ______ ☐ Yes ☐ No

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg / lbs Height ______ cm / in

Allergies ______

Prior Therapies ______

Concomitant Medications ______

______

Additional Comments ______

______

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
☐ Astagraf XL (tacrolimus)				
☐ Cellcept (mycophenolate mofetil)				
☐ Envarsus XR (tacrolimus)				
☐ Gengraf (cyclosporine modified)				
☐ Myfortic (mycophenolic acid)				
☐ Neoral (cyclosporine modified)				
☐ Nulojix (belatacept)				
☐ Prograf (tacrolimus)				
☐ Rapamune (sirolimus)				
☐ Sandimmune (cyclosporine)				
☐ Zortress (everolimus)				
☐ Prednisone				
☐ Other: ______				

****Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: ☐ Patient ☐ Office ☐ Other ______ Date ______ Needs by Date ______

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______ Date ______ Supervising Physician ______ Date ______

Electronically signed faxed prescriptions are not acceptable. A manual signature of the prescriber is required.

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