CompreCare | Rx

Specialty Pharmacy
JCAHO Accredited

TRANSPLANT ENROLLMENT FORM

Phone: 800-541-2030
Fax: 888-862-4769

PATIENT INFORMATION

Patient Name	Male ☐ Female ☐	Allergies NKDA
Date of Birth	SSN#	Weight Kg Lb Date / /
Address	City	State/Zip
Phone # (Home)	Work #	Email Address
Caregiver	Case Manager	

INSURANCE INFORMATION

Primary Insurance	Policy Holder
Group # Policy #	Phone #
Secondary Insurance Policy #	Phone #

DIAGNOSIS/MEDICAL INFORMATION (PLEASE SPECIFY PRIMARY & SECONDARY DIAGNOSIS)

☐ Heart (42.1) ☐ Liver (V42.7) ☐ Bone Marrow (42.81) ☐ Intestines (V42.84) ☐ Pancreas (V42.83) ☐ Kidney (V42.0) ☐ Lung (V42.6)
☐ Peripheral Stem Cells (42.82) ☐ Other specified organ or tissues (42.89):

☐ Other ICD-10 Description:

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
IMMUNOSUPPRESSANTS				
☐ Prograf (tacrolimus)	☐ 0.5mg			
☐ Prograf (tacrolimus)	☐ 1mg			
☐ Prograf (tacrolimus)	☐ 5mg			
☐ Gengraf (cyclosporine)	☐ 25mg			
☐ Gengraf (cyclosporine)	☐ 100mg			
☐ Neoral (cyclosporine)	☐ 25mg			
☐ Neoral (cyclosporine)	☐ 100mg			
☐ Cellcept (mycophenolate)	☐ 250mg			
☐ Cellcept (mycophenolate)	☐ 500mg			
☐ Myfortic (mycophenolic acid)	☐ 180mg			
☐ Myfortic (mycophenolic acid)	☐ 360mg			
☐ Rapamune (sirolimus)	☐ 1mg			
☐ Rapamune (sirolimus)	☐ 2mg			
☐ Zortress®	☐ 0.25mg			
☐ Zortress®	☐ 0.5mg			
☐ Zortress®	☐ 0.75mg			
☐ Prednisone	☐ 5mg			
PCP PROPHYLAXIS				
☐				
CMV PROPHYLAXIS				
☐				
☐				
TRUSH (CANDIDA)				
☐				
☐				
GASTROINTESTINAL				
☐				
☐				

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
ANTIHYPERTENSIVES				
☐				
☐				
☐				
☐				
DIABETIC SUPPLIES				
☐ Insulin ☐ Non Insulin Diagnosis Code: _____ ☐ Not a Diabetic				
☐ _____Glucometer	N/A			
☐ _____Test Strips	N/A			
☐ _____ Lancets	N/A			
☐ 0.5cc Insulin Syringes	N/A			
☐ Short-Acting Insulin:				
_____				
☐ Long-Acting Insulin:				
☐				
☐				
☐				
HEMATOPOIETICS				
OTHER MEDICATIONS				
☐				
☐				
☐				
☐				
☐				
☐				

DELIVERY INSTRUCTIONS

☐ Physician's Office ☐ Patient's Home ☐Other

Address Phone #

City/State/Zip Date Medication Needed / /

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Phone Fax
Address	City/State/Zip
NPI # DEA #	Office Contact
Physician Signature (signature required to process prescription)	Date