



Patient Name: _____ DOB: _____ Allergies: _____

Prescriber: _____ NPI: _____ ICD 10: _____ Date of transplant: _____

Please FAX recent clinical notes, labs, tests with the prescription to expedite Prior Authorization

X	Medication Name	Strength	Dose/Frequency	DAW?	Quantity	Refills
	Tacrolimus	0.5 mg			30 days	5
	Tacrolimus	1 mg			30 days	5
	Tacrolimus	5mg			30 days	5
	Mycophenolic	360 mg			30 days	5
	Mycophenolate	250 or 500mg			30 days	5
	Prednisone				30 days	5
	Gengraf	25 mg				
	Gengraf	50 mg				
	Gengraf	100 mg				
	Neoral	25 mg				
	Neoral	100 mg				
	Rapamune	0.5 mg				
	Rapamune	1 mg				
	Rapamune	2 mg				

Transplant team contact: _____ Phone: _____ Email: _____

Delivery contact person/phone: _____ Delivery location: _____

Date & time needed: _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

**** FAX DOES NOT CONSTITUTE A VAILD PRESCRIPTION AS PER NY STATE BOARD OF PHARMACY. KINDLY E-PRESCRIBE TO US ****