LeMed
SPECIALTY PHARMACY

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Bronx, NY 10451
Phone: 347-913-4656 Fax: 718-231-2727
www.lemedrx.com

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: _____

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