Zarina Pharmacy
SPECIALTY & INFUSION

**Skip this form & e-prescribe! Select BioPlus from your EHR!**

# TRANSPLANT

Fax: 832-886-4298
Phone: 832-886-4296
zarinapharmacy.com

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Name: | | SSN: | DOB: |
| Address: | City: | State: | ZIP: |
| Home Phone: | Cell: | Email: | Gender: ○ Female ○ Male |

## CLINICAL INFORMATION

| | | |
|---|---|---|
| Height: | Weight: | Allergies: |
| Transplant Date: | Projected Discharge Date: | Organ Transplanted: |

## INSURANCE INFORMATION (or attach copy of cards)

| | | | |
|---|---|---|---|
| Primary Insurance: | Phone: | Policy #: | Group #: |
| Secondary Insurance: | Phone: | Policy #: | Group #: |

## PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| **Astagraf XL®** *(tacrolimus)* extended-release capsules | ☐ 0.5 mg ☐ 1 mg ☐ 5 mg | | | |
| **Azasan®** (*azathioprine*) | ☐ 75 mg ☐ 100 mg | | | |
| **Cellcept®** *(mycophenolate mofetil)* capsules* | ☐ 200 mg/mL Powder for Suspension<br>☐ 250 mg ☐ 500 mg | | | |
| **Envarsus XR®** (*tacrolimus*) extended-release tablets | ☐ 0.75 mg ☐ 1 mg ☐ 4 mg | | | |
| **Imuran®** (*azathioprine*)* | ☐ 50 mg | | | |
| **Myfortic®** (*mycophenolic acid*)* | ☐ 180 mg ☐ 360 mg | | | |
| **Neoral®** (*cyclosporine*) | ☐ 25 mg ☐ 100 mg<br>☐ 100 mg/mL Oral Solution | | | |
| **Prograf®** (*tacrolimus*)* | ☐ 0.5 mg ☐ 1 mg ☐ 5 mg | | | |
| **Rapamune®** (*sirolimus*)* | ☐ 0.5 mg ☐ 1 mg ☐ 2 mg<br>☐ 1 mg/mL Oral Solution | | | |
| **Sandimmune®** (*cyclosporine*) * | ☐ 25 mg ☐ 100 mg<br>☐ 100 mg/mL Oral Solution | | | |
| **Zortress®** (*everolimus*) | ☐ 0.25 mg ☐ 0.5 mg ☐ 0.75 mg ☐ 1 mg | | | |
| ☐ **Other** | | | | |

*AVAILABLE IN GENERIC

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.

☐ Dispense as written

## PHYSICIAN INFORMATION

| | | | |
|---|---|---|---|
| Prescriber Name: | Phone: | Fax: | |
| Office Contact: | Email: | | |
| Address: | City: | State: | ZIP: |
| NPI #: | Tax ID #: | | |
| Prescriber Signature: | Date: | | |