Patient Referral/ Medication Request Transplant

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809
Phone: 1-866-782-2779 (1-866-782-ASRX)
FAX: 1-866-329-2779 (1-866-FAX-ASRX)
www.AetnaSpecialtyPharmacy.com

Today's Date: **Anticipated Start Date:**

PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB: Height:	Weight:	Allergies:	
Ship Meds to: ☐ Home ☐ Work ☐ Doctor's Office		Email Address:	

INSURANCE INFORMATION

Primary Insurance:		**Pharmacy Benefit Manager (PBM)**:	
Policy #:	Group #:	Insured:	Phone:
Medicare: ☐ Yes ☐ No	If Yes, provide #:	Medicaid: ☐ Yes ☐ No	If Yes, provide #:
Secondary Insurance:			
Policy #:	Group #:	Insured:	Phone:

PHYSICIAN INFORMATION

First Name:		Last Name: M.D./D.O.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:		Email Address:		Phone:	

VITAL INFORMATION:

Weight: ______________ kg, Height: ____________ Allergies: ________________________________

HOSPITAL INFORMATION:

Hospital Name:	Transplant Date:
New Transplant Patient ☐ YES ☐ NO	

DIAGNOSIS:

Primary:	ICD 9:	**Secondary**:	ICD 9:

☐ **CELLCEPT (MYCOPHENOLATE)** QTY: _______ Refills: ______
☐ 250mg ☐ 500mg ☐ 200mg/ml - 175 mL/BO
☐ Medically Necessary
Directions: ____________________________

☐ **MYFORTIC** QTY: _______ Refills: ______
☐ 180mg ☐ 360mg
☐ Medically Necessary
Directions: ____________________________

☐ **PROGRAF (TACROLIMUS)** QTY: _______ Refills: ______
☐ 0.5mg ☐ 1mg ☐ 5mg
☐ Medically Necessary
Directions: ____________________________

☐ **RAPAMUNE** QTY: _______ Refills: ______
☐ 0.5mg ☐ 1mg ☐ 2mg ☐ 1 mg/ml – 60 mL/BO
☐ Medically Necessary
Directions: ____________________________

☐ **VALCYTE** QTY: _______ Refills: ______
☐ 450mg
Directions: ____________________________

☐ **AZITHROMYCIN** QTY: _______ Refills: ______
☐ 250mg ☐ 500mg
Directions: ____________________________

☐ **BACTRIM (SMZ/TMP)** QTY: _______ Refills: ______
☐ DS 800/ 160mg ☐ SS 400/ 80mg
Directions: ____________________________

☐ **MYCLEX (CLOTRIMAZOLE)** QTY: _______ Refills: ______
☐ 10mg
Directions: ____________________________

☐ **NYSTATIN** QTY: _______ Refills: ______
☐ 100,000 units/mL
Directions: ____________________________

☐ **NEORAL (CYCLOSPORINE MODIFIED)** QTY: _______ Refills: ______
☐ 25mg ☐ 100mg ☐ 100mg/ml - 50 mL/BO
☐ Medically Necessary
Directions: ____________________________

☐ **GENGRAF (CYCLOSPORINE MODIFIED)** QTY: _______ Refills: ______
☐ 25mg ☐ 100mg
☐ Medically Necessary
Directions: ____________________________

☐ **SANDIMMUNE (CYCLOSPORINE NON-MODIFIED)**
QTY: _______ Refills: ______
☐ 0.5mg ☐ 1mg ☐ 5mg
☐ Medically Necessary
Directions: ____________________________

☐ **PREDNISONE** QTY: _______ Refills: ______
________ mg
Directions: ____________________________

☐ **METHYLPREDNISOLONE** QTY: _______ Refills: ______
________ mg
Directions: ____________________________

☐ **OTHER** ______________________ QTY: _______ Refills: ______
Directions: ____________________________

☐ **OTHER** ______________________ QTY: _______ Refills: ______
Directions: ____________________________

☐ **OTHER** ______________________ QTY: _______ Refills: ______
Directions: ____________________________

☐ **OTHER** ______________________ QTY: _______ Refills: ______
Directions: ____________________________

☐ **OTHER** ______________________ QTY: _______ Refills: ______
Directions: ____________________________

Prescriber's Signature Required by Law: **Date:**