LINDEN
RETAIL SPECIALTY PHARMACY

TRANSPLANT ENROLLMENT FORM

Phone: 908-583-6665 | Fax: 888-474-0976
Email: lindensprx@gmail.com

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name _____ Address _____ City, State, ZIP _____

Preferred Contact Methods ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone _____ Alternate Phone _____ Date of Birth _____ Gender ◯ Male ◯ Female

Email _____ Last Four of SSN _____ Primary Language _____

2 PRESCRIBER INFORMATION

Prescriber's Name _____ State License Number _____

NPI Number _____ DEA Number _____ Group or Hospital _____

Address _____ City, State, ZIP _____

Phone _____ Fax _____ Contact Person _____ Contact's Phone _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date _____ Ship to ☐ Patient ☐ Office ☐ Other _____

Diagnosis (ICD-10):

☐ Z94.0 Kidney Transplant Status
☐ Z94.1 Heart Transplant Status
☐ Z94.2 Lung Transplant Status
☐ Z94.3 Heart and Lung Transplant Status
☐ Z94.4 Liver Transplant Status
☐ Z94.5 Skin Transplant Status
☐ Z94.6 Bone Transplant Status
☐ Z94.7 Conceal Transplant Status
☐ Z94.81 Bone Marrow Transplant Status
☐ Z94.82 Intestine Transplant Status
☐ Z94.83 Pancreas Transplant Status
☐ Z94.84 Stem Cells Transplant Status
☐ Others _____ Description _____

Required Information for Organ Transplant Patients:

Patient Medicare status (check all that apply):

☐ Had Medicare at time of transplant ☐ Currently has Medicare ☐ Does not have Medicare

If patient has Medicare, please provide Medicare ID: _____

Date of Transplant: _____ Discharge Date: _____

Hospital Name, City and State: _____

For Kidney Transplant: Initial Dialysis Date _____ Type of Dialysis: ☐ Hemo ☐ Peritoneal

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

5 PRESCRIPTION INFORMATION (DIABETIC SUPPLIES)

☐ Not a Diabetic

☐ Insulin ☐ Non-Insulin Diagnosis Code: _____

Glucometer: _____

Test Strips: _____

Lancets: _____

0.5 cc Insulin Syringes : _____

Short Acting Insulin: _____

Long-Acting Insulin: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED _____ (Date) _____ DISPENSE AS WRITTEN _____ (Date) _____

Please complete Patient and Prescriber Information

Patient Name: ____________ Patient Date of Birth: ____________

Prescriber Name: ____________ Prescriber Phone: ____________

5 PRESCRIPTION INFORMATION (IMMUNOSUPPRESSANTS)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Astagraf XL®	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	☐ Other :	Quantity: Refills:
☐ Azasan®	☐ 75 mg ☐ 100 mg	☐ Other :	Quantity: Refills:
☐ Cellcept®	☐ 250 mg ☐ 500 mg ☐ 200 mg/mL	☐ Other :	Quantity: Refills:
☐ Envarsus XR®	☐ 0.75 mg ☐ 1 mg ☐ 4 mg	☐ Other :	Quantity: Refills:
☐ Gengraf®	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	☐ Other :	Quantity: Refills:
☐ Imuran®	☐ 50 mg	☐ Other :	Quantity: Refills:
☐ Myfortic®	☐ 180 mg ☐ 360 mg	☐ Other :	Quantity: Refills:
☐ Neoral®	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	☐ Other :	Quantity: Refills:
☐ Prednisone	☐ 5 mg ☐ 10 mg	☐ Other :	Quantity: Refills:
☐ Prograf®	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	☐ Other :	Quantity: Refills:
☐ Rapamune®	☐ 0.5 mg ☐ 1 mg ☐ 2 mg ☐ 1 mg/mL	☐ Other :	Quantity: Refills:
☐ Sandimmune®	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	☐ Other :	Quantity: Refills:
☐ Zortress®	☐ 0.25 mg ☐ 0.50 mg ☐ 0.75 mg	☐ Other :	Quantity: Refills:

5 PRESCRIPTION INFORMATION (OTHER)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ PCP Prophylaxis:	☐ Other:	☐ Other:	Quantity: Refills:
☐ PCP Prophylaxis:	☐ Other:	☐ Other:	Quantity: Refills:
☐ CMV Prophylaxis:	☐ Other:	☐ Other:	Quantity: Refills:
☐ CMV Prophylaxis:	☐ Other:	☐ Other:	Quantity: Refills:
☐ Thrush (Candida):	☐ Other:	☐ Other:	Quantity: Refills:
☐ Hematopoietics:	☐ Other:	☐ Other:	Quantity: Refills:
☐ Hematopoietics:	☐ Other:	☐ Other:	Quantity: Refills:
☐ Gastrointestinal:	☐ Other:	☐ Other:	Quantity: Refills:
☐ Gastrointestinal:	☐ Other:	☐ Other:	Quantity: Refills:
☐ Gastrointestinal:	☐ Other:	☐ Other:	Quantity: Refills:
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☐ Other:	☐ Other:	☐ Other:	Quantity: Refills:

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

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