

REFERRAL ADDRESS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Intake Supervisor:  
Susanne Jane  
(323)201-4488

Transplant Medication Program

ORDER FORM

**FAX: (866)728-4810**

Prescribing Information:

Patient Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ HICN#: \_\_\_\_\_

CMV Status: Recipient \_\_\_\_\_ Donor \_\_\_\_\_ Allergies:  NKA \_\_\_\_\_

*(All medications are to be dispensed as a 30-day supply)*

Medication	Directions for Use	Refills
<input type="checkbox"/> Neoral 100mg capsules	_____	_____
<input type="checkbox"/> Neoral 25mg capsules	_____	_____
<input type="checkbox"/> Prograf 1mg capsules	_____	_____
<input type="checkbox"/> CellCept 250mg capsules	_____	_____
<input type="checkbox"/> Prednisone 5mg tablets	_____	_____
<input type="checkbox"/> Itraconazole 100mg capsules	_____	_____
<input type="checkbox"/> Diflucan 100mg tablets	_____	_____
<input type="checkbox"/> Valcyte 450mg tablets	_____	_____
<input type="checkbox"/> Acyclovir 800mg capsules	_____	_____
<input type="checkbox"/> Protonix 40mg tablets	_____	_____
<input type="checkbox"/> Prilosec 20mg tablets	_____	_____
<input type="checkbox"/> Prevacid 30mg capsules	_____	_____
<input type="checkbox"/> Septra SS tablets	_____	_____
<input type="checkbox"/> Ciprofloxacin 250mg tablets	_____	_____
<input type="checkbox"/> Magnesium Oxide 400mg tablets	_____	_____
<input type="checkbox"/> K-Phos Neutral 250mg tablets	_____	_____
<input type="checkbox"/> Kayexelate 15gm in 60ml Sorbitol	_____	_____
<input type="checkbox"/> 2 oz. empty bottle	_____	_____
<input type="checkbox"/> Tylenol 325mg tablets	_____	_____
<input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

<b>Delivery Instructions:</b>	<b>Date Medication Needed:</b> _____
<input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office	<input type="checkbox"/> Other
<b>Physician Contact Information &amp; Authorization:</b>	<b>Name</b> _____
Signature: _____	License: _____ DEA: _____ UPIN: _____
Contact Person:	
<input type="checkbox"/> _____	<input type="checkbox"/> _____

Please mail the original of this document to: **University Specialty Pharmacy, Attn: Intake Department**  
**3328 GARFIELD AVE., COMMERCE, CA 90040-3302**