Transplant Enrollment Form

InfuCare Rx

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Name:			Prescribing Practitioner:		NPI:
Address:			Address:		
City:	State/Zip:		City:		State/Zip:
Telephone:	DOB:	M ☐ F ☐	Office:		DEA:
Language Preference:	Wt:	Ht:	Contact:	Phone:	Fax:

PLEASE FAX COPY OF: ☐ PRESCRIPTION FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

PRIMARY INSURANCE INFORMATION

Member Name:	M ☐ F ☐	DOB:	
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	Please attach a copy of the front and back of the patient's insurance card, if available.*****	

PRESCRIPTION

☐ New ☐ Refill | Ship by: | Organ Type: ☐ Heart ☐ Kidney ☐ Liver ☐ Lung ☐ Pancreas ☐ Other:_____

Drug	Strength	Directions	Quantity	Refills
☐ Aspirin®				
☐ Clotrimazole®				
☐ Colace®				
☐ Gengraf®				
☐ MVI®				
☐ Myfortic®				
☐ Noeral®				
☐ Nystatin®				
☐ Pepcid®				
☐ Prednisone®				
☐ Prograf®				
☐ Rapamune®				
☐ SMX/TMP®				
☐ Valcyte®				
☐ Other:				
☐ Other:				

DIAGNOSIS AND CLINICAL INFORMATION

***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

Diagnosis Description and ICD10:

Additional Clinical Information:

Allergies:

Date of Transplant: ____/____/_____

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature:	Date: