ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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TRANSPLANTASSIST®
ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 10.31.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

www.commcarepharmacy.com

Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: Diagnosis/ICD-10-CM Codes: Date of Diagnosis:_____ □Heart(Z94.1) □Kidney(Z94.0) □Lung(Z94.2)
□Liver(Z94.4) □Bone Marrow(Z94.81) □Pancreas(Z94.83) □Intestines(Z94.82) □Peripheral Stem Cells(Z94.84) □Other_____

Requested Clinical Information: Date of Transplant: _____
If Medicare patient, please answer the following questions:
Name of Facility where Transplant was performed _____ Date of Admission _____ Date of Discharge (or estimated date of Discharge) _____
Was there a prior transplant failure of the same organ? □Yes □No

I. Immunosuppressants: *Please specify if brand name product to be dispensed by handwriting "Brand Medically Necessary" in the directions*

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
□Astagraf XL® (tacrolimus XL)	□ 0.5mg □ 1mg □ 5mg			
□Cellcept® (mycophenolate mofetil)	□ 250mg □ 500mg			
□Envarsus XR® (tacrolimus XL)	□ 0.75mg □ 1mg □ 4mg			
□Gengraf® (Cyclosporine)	□ 25mg □ 100mg			
□Hecoria™ (tacrolimus)	□ 0.5mg □ 1mg □ 5mg			
□Myfortic® (mycophenolic acid)	□ 180mg □ 360mg			
□Neoral® (cyclosporine)	□ 25mg □ 100mg			
□Prednisone	□ 5mg □ 10mg			
□Prograf® (tacrolimus)	□ 0.5mg □ 1mg □ 5mg			
□Rapamune® (sirolimus)	□ 1mg □ 2mg			
□Other				

II. Supportive Medications: *Please specify if medical necessity (Dispense as Written) with physician signature and date*

□Other				

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation)_____ Date:_____ □ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program