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# TRANSPLANTASSIST® ENROLLMENT FORM

Today's Date: \_\_\_\_\_  
 Needed By: \_\_\_\_\_

Last update 10.31.2018



www.commcarepharmacy.com  
 Plantation, FL  
 Phone: 888.203.7973  
 Fax: 888.203.7980  
 NCPDP: 1079638  
 NPI: 1598762015

|  |  |
|--|--|
| <b>Patient Demographics:</b> (Please provide the following or attach demographics sheet) | <b>Provider Office:</b> (Please provide as much information as possible) |
| Patient Name: _____  | Prescriber's Name: _____ Group/Hospital: _____                           |
| Address: _____   | Specialty: _____ License#: _____ Tax ID#: _____                          |
| City, State, Zip: _____  | Address: _____   |
| Preferred Phone: _____ Alt. Phone: _____   | NPI: _____ DEA: _____  |
| Last four digits of SS#: _____ Date of Birth: _____                                      | City, State, Zip: _____  |
| Gender: _____ Allergies: _____ Height: _____ Weight: _____                               | 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 |
|--|---------------------------------|------------|----------|---------|
| <input type="checkbox"/> Astagraf XL® (tacrolimus XL)      | <input type="checkbox"/> 0.5mg  |            |          |         |
|  | <input type="checkbox"/> 1mg    |            |          |         |
|  | <input type="checkbox"/> 5mg    |            |          |         |
| <input type="checkbox"/> Cellcept® (mycophenolate mofetil) | <input type="checkbox"/> 250mg  |            |          |         |
|  | <input type="checkbox"/> 500mg  |            |          |         |
| <input type="checkbox"/> Envarsus XR® (tacrolimus XL)      | <input type="checkbox"/> 0.75mg |            |          |         |
|  | <input type="checkbox"/> 1mg    |            |          |         |
|  | <input type="checkbox"/> 4mg    |            |          |         |
| <input type="checkbox"/> Gengraf® (Cyclosporine)           | <input type="checkbox"/> 25mg   |            |          |         |
|  | <input type="checkbox"/> 100mg  |            |          |         |
| <input type="checkbox"/> Hecoria™ (tacrolimus)             | <input type="checkbox"/> 0.5mg  |            |          |         |
|  | <input type="checkbox"/> 1mg    |            |          |         |
|  | <input type="checkbox"/> 5mg    |            |          |         |
| <input type="checkbox"/> Myfortic® (mycophenolic acid)     | <input type="checkbox"/> 180mg  |            |          |         |
|  | <input type="checkbox"/> 360mg  |            |          |         |
| <input type="checkbox"/> Neoral® (cyclosporine)            | <input type="checkbox"/> 25mg   |            |          |         |
|  | <input type="checkbox"/> 100mg  |            |          |         |
| <input type="checkbox"/> Prednisone                        | <input type="checkbox"/> 5mg    |            |          |         |
|  | <input type="checkbox"/> 10mg   |            |          |         |
| <input type="checkbox"/> Prograf® (tacrolimus)             | <input type="checkbox"/> 0.5mg  |            |          |         |
|  | <input type="checkbox"/> 1mg    |            |          |         |
|  | <input type="checkbox"/> 5mg    |            |          |         |
| <input type="checkbox"/> Rapamune® (sirolimus)             | <input type="checkbox"/> 1mg    |            |          |         |
|  | <input type="checkbox"/> 2mg    |            |          |         |
| <input type="checkbox"/> Other                             |                                 |            |          |         |

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

|                                |  |  |  |  |
|--------------------------------|--|--|--|--|
| <input type="checkbox"/> 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  
**CONFIDENTIALITY NOTICE:** If you are not the intended recipient or the person responsible for delivering it to the intended recipient, you are hereby notified that you are not authorized to read, print, retain, copy or disseminate this message, any part of it, or any attachments. This facsimile message may contain information that is confidential, privileged, proprietary, or otherwise legally exempt from disclosure or use. **Any disclosure or use of this facsimile message by any person other than the intended recipient or person responsible for delivering it to the intended recipient may constitute a Federal criminal offense punishable by imprisonment up to 10 years or fines up to \$250,000.** If you have received this message in error, please destroy this message and any accompanying attachments in their entirety without reading the content and notify the sender immediately by telephone of the inadvertent transmission, by calling collect if located outside the calling area. There is no intent on the part of the sender to waive any right or privilege that may be attached to this communication. Thank you for your cooperation. \*This prescription is valid only if transmitted by means of a facsimile machine from the authorized prescriber.