Gigi Specialty Pharmacy

Transplant Enrollment Form

A Dose Of Kindness With Every Perscription.

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

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____

Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

PRESCRIBER INFORMATION

Prescriber's Name _____

State License # _____ UPIN _____

DEA _____ NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION

Prescription Card: Name of Insurer _____ ID # _____ BIN _____ PCN _____ Group _____

Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

MEDICAL INFORMATION

Diagnosis

Hospital name _____

Date of Discharge _____

Please include diagnosis name and ICD-10

☐ ICD-10_____ Diagnosis _____

Transplant Type:

☐ Heart ☐ Kidney ☐ Liver ☐ Lung ☐ Pancreas

☐ Other _____

Date of Transplant _____

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
☐ Prograf (tacrolimus) ☐ Hecoria (tacrolimus)				
☐ Gengraf (cyclosporine) ☐ Neoral (cyclosporine)				
☐ CellCept (mycophenolate mofetil) ☐ Myfortic (mycophenolic acid)				
☐ Rapamune (sirolimus)				
☐ Zortress				
☐ Prednisone				
☐ Imuran (azathiprine)				

Prescriber's Signature _____

PRODUCT SUBSTITUTION PERMITTED _____ *DISPENSE AS WRITTEN*