Galaxy SPECIALTY PHARMACY
(Christus SantaRosa Hospital, Tower # 1)

Faxed prescriptions will only be accepted from a prescribing practitioner.
Patients must bring an original prescription to the pharmacy.

Transplant Prescription Referral Form

2829 Babcock Road, Suite # 120 • San Antonio- 78229, TX • Ph : 210.617.4311 • Fax: 210.617.4312
www.GalaxySpecialtyPharmacy.com

Date Medication Needed: _____ **Ship To:** ◯ Patient's Home ◯ Prescriber's Office ◯ Pick-up _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** Male Female **Height:** _____ **Weight:** _____ lbs. kg.
Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

_____ _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____
Address: _____ **Phone:** (_____) _____ - _____ **Fax:** (_____) _____ - _____
City: _____ **State:** _____ **Zip:** _____ **Key Contact:** _____ **Phone:** (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Transplant Date: _____ **Anticipated Discharge Date:** _____ **Organ Transplanted (choose one):**

4: Prescription Information

Medication	Dose/Strength	Max. Daily Dosage	Sig	Qty.	Refills
Prograf®	0.5mg 1mg 5mg				
Tacrolimus (Compounded Tacrolimus Liquid)	0.5mg/1ml 1mg/1ml				
Rapamune® (Sirolimus)	0.5mg 1mg 2mg 1mg/ml				
Neoral®	25mg 100mg 100mg/ml				
Myfortic® (Mycophenolic Acid)	180mg 360mg				
Cellcept®	200mg/ml 250mg 500mg				
Valcyte™ (Valganciclovir)	450mg 50mg/ml				
VFend	50mg 200mg 40mg/ml				
Zortress	0.25mg 0.5mg 0.75mg				
Hecoria	0.5mg 1mg 5mg				
Transplant Kit (BP monitor, therm., pill cutter, pill box, blood pressure cuff) Cuff Size: S M L	1 package		Use as directed	1	

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____