Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

SOLID ORGAN TRANSPLANT REFERRAL FORM (immunosuppression)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **B25.9** cytomegalovirus (CMV) prophylaxis and/or treatment
- ☐ **B44.9** *Aspergillus* prophylaxis and/or treatment
- ☐ **B59** Pneumocystis PNA (PCP/PJP) prophylaxis and/or treatment
- ☐ **Z94.0** kidney replaced by transplant — ☐ Other:
- ☐ **Z94.2** lung replaced by transplant — ☐ Other:
- ☐ **Z94.3** heart replaced by transplant — ☐ Other:
- ☐ **Z94.4** liver replaced by transplant — ☐ Other:

Date of transplant: **Labs** *(please attach most recent results)*: ☐ CMP ☐ CMV level ☐ C&S report(s)

Current medication(s) with date(s) started:

Prior medication(s) with date(s) of use:

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
☐ **transplant bag**	Check here for BP monitor, thermometer, sunscreen, lip balm, pill splitter, pill organizer, hand sanitizer, & masks			
Immunosuppression				
☐ azathioprine	**Tabs**: ☐ 50mg ☐ 75mg ☐ 100mg			
☐ cyclosporine, modified (Gengraf, Neoral)	**Caps**: ☐ 25mg ☐ 50mg ☐ 100mg **Soln**: ☐ 100mg/mL			
☐ cyclosporine, non-modified (SandIMMUNE)	**Caps**: ☐ 25mg ☐ 50mg ☐ 100mg **Soln**: ☐ 100mg/mL			
☐ Envarsus	**Tabs**: ☐ 1mg ☐ 4mg			
☐ everolimus (Zortress)	**Tabs**: ☐ 0.25mg ☐ 0.5mg ☐ 0.75mg ☐ 1mg			
☐ mycophenolate mofetil (Cellcept)	**Caps**: ☐ 250mg **Tabs**: ☐ 500mg			
☐ mycophenolic acid (Myfortic)	**Tabs**: ☐ 180mg ☐ 360mg			
☐ prednisone	**Tabs**: ☐ 1mg ☐ 5mg ☐ 10mg			
☐ sirolimus (Rapamune)	**Tabs**: ☐ 0.5mg ☐ 1mg ☐ 2mg **Soln**: ☐ 1mg/mL			
☐ tacrolimus (Prograf)	**Caps**: ☐ 0.5mg ☐ 1mg ☐ 5mg			
Other:				

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.

SYNERGEN Rx Specialty Pharmacy

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SOLID ORGAN TRANSPLANT REFERRAL FORM

(opportunistic infection prophylaxis and treatment)

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **B25.9** cytomegalovirus (CMV) prophylaxis and/or treatment
- ☐ **B44.9** *Aspergillus* prophylaxis and/or treatment
- ☐ **B59** Pneumocystis PNA (PCP/PJP) prophylaxis and/or treatment
- ☐ **Z94.0** kidney replaced by transplant ☐ Other:
- ☐ **Z94.2** lung replaced by transplant ☐ Other:
- ☐ **Z94.3** heart replaced by transplant ☐ Other:
- ☐ **Z94.4** liver replaced by transplant ☐ Other:

Date of transplant: **Labs** *(please attach most recent results)*: ☐ CMP ☐ CMV level ☐ C&S report(s)

Current medication(s) with date(s) started:

Prior medication(s) with date(s) of use:

PRESCRIPTION

☐ **DAW** **(**deliver to ☐ patient ☐ office)

Medication	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
Prophylaxis and/or Treatment, *Aspergillus*				
☐ Cresemba	**Caps**: ☐ 74.5mg ☐ 186mg	☐ **Initiation**: 372mg PO Q8h x 6 doses ☐ **Maintenance**: 372mg PO once daily		
☐ posaconazole	**Susp**: ☐ 40mg/mL **Tabs**: ☐ 100mg			
☐ voriconazole	**Susp**: ☐ 40mg/mL **Tabs**: ☐ 50mg ☐ 200mg			
Prophylaxis and/or Treatment, CMV				
☐ Livtencity	200mg tablet	400mg PO twice daily for ____ weeks		
☐ Prevymis	**Tabs**: ☐ 240mg ☐ 480mg	____ mg PO once daily for ____ weeks		
☐ valacyclovir	**Tabs**: ☐ 500mg ☐ 1g			
☐ valganciclovir (Valcyte)	**Soln**: ☐ 50mg/mL **Tabs**: ☐ 450mg			
Prophylaxis and/or Treatment, PCP/PJP				
☐ atovaquone	750mg/5mL suspension	10mL (1.5g) PO once daily		
☐ SMZ/TMP	**Susp**: ☐ 200/40mg per 5mL **Tabs**: ☐ 800/160mg ☐ 400/80mg			
Other:				

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.