FACTOR ONE SOURCE FAST PHARMACY

FAX 1-844-504-3278
PHONE 1-877-327-8881
www.FASTACCESSRX.com

TRANSPLANT FORM

PATIENT INFORMATION:

Patient Name:_____
Date of Birth:_____Male:☐ Female:☐
Address:_____
City/State/Zip:_____
Tel:_____Alt Tel:_____
SS#:_____Wt:_____Ht:_____
NKDA:☐ Allergy:_____

INSURANCE INFORMATION:

Primary Pharmacy Insurance_____
Member Name:_____
Member ID:_____
Rx Group #:_____
BIN#_____PCN#_____
Customer Service #:_____
Please attach a copy of the front and back of the patient's insurance card, if available.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis (Description and ICD10):_____
Organ Type: ☐Heart ☐ Kidney ☐ Liver ☐Lung ☐Pancreas ☐
Other:_____
Date of Transplant:_____

PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
NPI#:_____DEA #:_____UPIN #:_____

By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Printed Name:_____Date:_____
Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Aspirin	_____	_____	_____	_____
☐ Clotrimazole	_____	_____	_____	_____
☐ Colace	_____	_____	_____	_____
☐ Gengraf	_____	_____	_____	_____
☐ MVI	_____	_____	_____	_____
☐ Myfortic®	_____	_____	_____	_____
☐ Neoral®	_____	_____	_____	_____
☐ Nystatin®	_____	_____	_____	_____
☐ Pepcid®	_____	_____	_____	_____
☐ Prednisone	_____	_____	_____	_____
☐ Prograf®	_____	_____	_____	_____
☐ Rapamune®	_____	_____	_____	_____
☐ SMX/TMP	_____	_____	_____	_____
☐ Valcyte®	_____	_____	_____	_____
☐ Other	_____	_____	_____	_____