BioPlus® Specialty Pharmacy

A Carelon Company

Heart and Lung Transplant

Fax: 800-269-5493 Phone: 888-292-0744 bioplusrx.com/therapy

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Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone		Fax
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ Z94.1 Heart Transplant ☐ Z94.2 Lung Transplant		Date of Transplant	Print Labels in: ☐ English ☐ Spanish
Allergies: ☐ NKDA ☐ Other: _____	Weight ☐ kg ☐ lbs	Height ☐ ft ☐ in	Status: ☐ New ☐ Restart ☐ Continuing

Medication	Directions for Use	DNS	Qty	Refills

☐,M.D.– DEA#, LIC#	☐,M.D.– DEA#, LIC#	☐,M.D.– DEA#, LIC#
☐,M.D.– DEA#, LIC#	☐,M.D.– DEA#, LIC#	☐,M.D.– DEA#, LIC#

Contact Person	☐	☐	☐

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

_____ _____ _____ _____

Prescriber's Signature (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**