



SPECIALTY PHARMACY

TRANSPLANT

Garden Grove, CA toll free 888.206.1872 toll free fax 888.206.3561

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: Z94.0 Kidney Transplant Z94.83 Pancreas Transplant Z94.4 Liver Transplant Z94.82 Intestine Transplant

Date of Transplant: _____
 Print Labels in: Spanish English

Height: _____ Weight: _____ Allergies: _____ NKDA

MEDICATION	DIRECTIONS FOR USE	QTY	RF	DNS
<input type="checkbox"/> ,M.D.– DEA#, LIC#	<input type="checkbox"/> ,M.D.– DEA#, LIC#	<input type="checkbox"/> ,M.D.– DEA#, LIC#		
<input type="checkbox"/> ,M.D.– DEA#, LIC#	<input type="checkbox"/> ,M.D.– DEA#, LIC#	<input type="checkbox"/> ,M.D.– DEA#, LIC#		
Contact Person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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