



Fax the completed form to
(818) 236-2504

Questions? Call (818) 236-2500
Monday to Friday, 10 am to 6 pm

E-prescribing? Send to Foothill Remedy Drugs
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

1 Patient

Or attach a patient face sheet

Last name _____ First name _____ Date of birth _____

Sex ☐ F ☐ M ☐ X Height _____ Weight _____ ☐ kg ☐ lb Allergies ☐ None known _____

Address _____ City _____ State _____ ZIP _____

Cell phone _____ Other phone _____ Email _____

Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other _____

2 Insurance

Or attach copies of the cards, front and back

Primary plan _____ Member ID _____ Group # _____ Phone _____

Secondary plan _____ Member ID _____ Group # _____ Phone _____

3 Prescriber

Prescriber name _____ NPI _____ License # _____

Practice _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Office contact _____

Contact phone _____ Contact email _____

4 Clinical information

Please attach recent labs and notes

Organ ☐ Kidney (Z94.0) ☐ Liver (Z94.4) ☐ Heart (Z94.1) ☐ Lung (Z94.2) ☐ Pancreas (Z94.83) ☐ Other _____

Transplant date _____ Transplant center _____

Did Medicare pay for the transplant? ☐ Yes ☐ No ☐ Unknown This tells us whether to bill Medicare Part B or Part D.

Tacrolimus level _____ ng/mL Goal _____ Creatinine _____ Lab date _____

Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from _____

Reason for switching _____

Current medications ☐ List attached _____

5 Delivery

Needed by _____ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy

Delivery is free within 25 miles of our Tujunga store.

Patient name _____ Date of birth _____

6 Prescription

Check each medication to fill. Directions and quantity can be changed.

Medication	Strength	Directions	Quantity	Refills
Tacrolimus				
☐ Tacrolimus Prograf or generic	0.5, 1 or 5 mg capsule	Take ____ mg by mouth every 12 hours	30-day supply	_____
☐ Envarsus XR tacrolimus extended-release	0.75, 1 or 4 mg tablet	Take ____ mg by mouth once daily	30-day supply	_____
☐ Astagraf XL tacrolimus extended-release	0.5, 1 or 5 mg capsule	Take ____ mg by mouth once daily in the morning	30-day supply	_____
Other immunosuppressants				
☐ Mycophenolate mofetil CellCept or generic	250 mg cap or 500 mg tab	Take ____ mg by mouth twice daily	30-day supply	_____
☐ Mycophenolic acid DR Myfortic or generic	180 mg or 360 mg tablet	Take ____ mg by mouth twice daily	30-day supply	_____
☐ Azathioprine Imuran or generic	50 mg tablet	Take ____ mg by mouth once daily	30-day supply	_____
☐ Cyclosporine modified Neoral, Gengraf or generic	25 mg or 100 mg capsule	Take ____ mg by mouth every 12 hours	30-day supply	_____
☐ Sirolimus Rapamune or generic	0.5, 1 or 2 mg tablet	Take ____ mg by mouth once daily	30-day supply	_____
☐ Everolimus Zortress or generic	0.25 to 1 mg tablet	Take ____ mg by mouth twice daily	30-day supply	_____
☐ Prednisone prednisone	1, 5, 10 or 20 mg tablet	Take ____ mg by mouth once daily	30-day supply	_____
Infection prevention				
☐ Valganciclovir Valcyte or generic	450 mg tablet	Take 2 tablets (900 mg) by mouth once daily with food	60 tablets	_____
☐ Sulfamethoxazole-trimethoprim Bactrim or generic	400/80 mg (SS) tablet	Take 1 tablet by mouth once daily	30 tablets	_____

Other medication (write in)

☐	_____	_____	_____	_____
☐	_____	_____	_____	_____

7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature _____ Date _____

☐ Do not substitute Prescriber initials _____ California law requires the prescriber to initial this box to prevent substitution.