



# PRESCRIPTION REQUEST FORM

Please complete and fax to 1-844-475-8931

For assistance or additional information,  
call 1-844-VELOXIS, M-F, 9 am - 7 pm EST.



**Transplant Support**  
1-844 VELOXIS (835-6947)

## 1. PATIENT INFORMATION

PATIENT NAME (First, MI, Last): \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_

SHIP TO ADDRESS (if different from patient address above; no P.O. Box or third-party vendor):

\_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

OTHER MEDICATIONS: \_\_\_\_\_

## 2. PRESCRIPTION INFORMATION

I authorize Veloxis Transplant Support to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy.

MEDICATION: ENVARUSUS XR® (tacrolimus extended-release tablets) 30-day Voucher Provided?  Yes  No Date: \_\_\_\_\_

DOSE 0.75 mg QUANTITY: \_\_\_\_\_ SCHEDULE/FREQUENCY: \_\_\_\_\_ DAYS SUPPLY: \_\_\_\_\_ # OF REFILLS: \_\_\_\_\_

DOSE 1 mg QUANTITY: \_\_\_\_\_ SCHEDULE/FREQUENCY: \_\_\_\_\_ DAYS SUPPLY: \_\_\_\_\_ # OF REFILLS: \_\_\_\_\_

DOSE 4 mg QUANTITY: \_\_\_\_\_ SCHEDULE/FREQUENCY: \_\_\_\_\_ DAYS SUPPLY: \_\_\_\_\_ # OF REFILLS: \_\_\_\_\_

DIRECTIONS: \_\_\_\_\_

Your state may require that prescriptions follow certain content requirements or use a particular form. By signing below, you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the states in which you are prescribing. I authorize Veloxis Transplant Support to act on my behalf for the limited purposes of transmitting this order for prescription medication.

X \_\_\_\_\_  
 SUBSTITUTION PERMITTED Prescriber Signature Date

Original Signature Required. No Stamps Allowed.

X \_\_\_\_\_  
 DISPENSE AS WRITTEN Prescriber Signature Date

Original Signature Required. No Stamps Allowed. Prescription is only valid if received by fax.

Special Note: New York prescribers, please submit prescription on an original NY State prescription blank. For all other States, if not faxed, must be on State-specific prescription blank if applicable for your State.

## 3. HEALTHCARE PROVIDER INFORMATION

PRINTED PRESCRIBER NAME AND TITLE: \_\_\_\_\_ DEA # (as required): \_\_\_\_\_

STATE LICENSE # AND STATE: \_\_\_\_\_ NPI #: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

IMPORTANT: This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.