Veloxis

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: ENVARSUS 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: _____