For assistance, contact your pharmacy representative: _____ Phone: _____ **(For providers only)**

**PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.**

**Note:** This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens + PRIME

# Endocrinology

Prescription/Pharmacy Intake Form

Pharmacy: _____

Pharmacy Fax: _____ Pharmacy Phone: _____

Ship To: ☐Prescriber's Office ☐Patient's Home ☐Other: _____

**Injection/Infusion Date:** _____ **Date Needed:** _____ ☐Physician provides injection training

## PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address: _____ Case Manager: _____

Insurance provider **(Please include copy of front and back of card)**: _____

ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

Will there be access to anaphylactic medications and oxygen at the administration site?_____

## CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: _____

Primary Diagnosis Code and Condition (ICD-10) **(REQUIRED)**: _____ Date of Diagnosis: _____

Other Diagnosis/Conditions: _____

Current Height: _____ ☐in ☐cm Date: _____ Bone Age: _____ Growth Velocity: _____

☐Other Therapies Tried & Failed (Please List): _____

Allergies: _____

## PRESCRIPTION INFORMATION

**Genotropin** Qty _____ Refills _____
- ☐5mg cartridge
- ☐12mg cartridge
- ☐Miniquik PFS Strength:_____

Directions: _____

**Humatrope** Qty _____ Refills _____
- ☐5mg vial
- ☐6mg cartridge
- ☐12mg cartridge
- ☐24mg cartridge

Directions: _____
- ☐**Humatropen** (device for injection)

**Increlex** Qty _____ Refills _____
- ☐4mL vial (10mg/1mL)

Directions: _____

**Lupron Depot** Qty _____ Refills _____
- ☐7.5mg (once monthly)
- ☐22.5mg (every 12 weeks)
- ☐30mg (every 16 weeks)
- ☐45mg (every 24 weeks)

Directions: _____

**Lupron Depot-Ped (Pediatric)** Qty ____ Refills _____
- ☐7.5mg (once monthly)
- ☐11.25mg (once monthly)
- ☐15mg (once monthly)
- ☐11.25mg (every 3 months)
- ☐30mg (every 3 months)

Directions: _____

**Norditropin Flexpro** Qty ____ Refills _____
- ☐5mg/1.5mL
- ☐10mg/1.5mL
- ☐15mg/1.5mL
- ☐30mg/3mL

Directions: _____

**Nutropin AQ NUSPIN Pen** Qty ____ Refills _____
- ☐5mg
- ☐10mg
- ☐20mg

Directions: _____

**Omnitrope*** Qty ____ Refills _____
- ☐5.8mg MDV
- ☐5mg cartridge
- ☐10mg cartridge

Directions: _____

**Saizen** Qty _____ Refills _____
- ☐5mg vial
- ☐8.8mg vial
- ☐8.8mg Click Easy cartridge

Directions: _____

**Sandostatin LAR Depot** Qty _____ Refills _____
- ☐10mg kit
- ☐20mg kit
- ☐30mg kit

Directions: _____

**Somatuline Depot** Qty _____ Refills _____
- ☐60mg/0.2ml PFS
- ☐90mg/0.3ml PFS
- ☐120mg/0.5ml PFS

Directions: _____

**Supprelin LA** Qty 1 Refills N/A
- ☐50mg implant (implant kit included)

Directions: _____

Contact phone number for surgeon's office doing implantation _____

**Zomacton** Qty _____ Refills _____
- ☐5mg vial
- ☐10mg vial
- ☐10mg vial with vial adapter

Directions: _____

***AllianceRx Walgreens Prime does not dispense Omnitrope device. Please contact Access Sandoz Program at 877-828-1052(fax) or 877-456-6794(phone).**

**I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.**

## PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date

**The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.**

The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.

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