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 MD office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens Pharmacy

Blood Cancers

Prescription/Pharmacy Intake Form

Pharmacy: Specialty360 Oncology - Phone: 866-202-4888 Fax: 888-440-6703

Pharmacy Fax: _____ Pharmacy Phone: _____

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

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip code: _____

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

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

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

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

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

ICD-10 code: _____ ICD-10 description: _____

Weight: _____ ☐lb ☐kg Date: _____ Height: _____ ☐in ☐cm Date: _____ BSA: _____ m^2

Allergies: _____

Please indicate the documents(s) attached:

☐Failed therapies ☐Recent laboratory results ☐Recent pathology report ☐Recent office notes ☐Copy of front and back of insurance card

17p Deletion	☐Positive ☐Negative	**IDH2 mutation**	☐Positive ☐Negative
D816V c-Kit	☐Positive ☐Negative	**JAK2 Status**	☐Positive ☐Negative
Deletion 5q	☐Positive ☐Negative	**PDGFR gene re-arrangements**	☐Positive ☐Negative
FIP1L1-PDGFRα fusion kinase	☐Positive ☐Negative	**Philadelphia Chromosome**	☐Positive ☐Negative
FLT3 mutation	☐Positive ☐Negative	**T315I mutation**	☐Positive ☐Negative

Medication	Dose/Directions/Frequency	Quantity	Refills
☐Bosulif ☐Calquence* ☐Daurismo† ☐Gleevec ☐Idhifa ☐Inqovi ☐Inrebic ☐Intron A ☐Jakafi ☐Matulane ☐Ninlaro ☐Onureg ☐Rydapt ☐Scemblix ☐Sprycel ☐Targretin ☐Tasigna ☐Zolinza ☐Other: _____			
†**If prescribing Daurismo:** ☐Cytarabine			
☐Dexamethasone ☐Hemady			
☐Pomalyst ☐Revlimid ☐Thalomid			**N/A**

For Pomalyst, Revlimid, Thalomid:

☐Adult female – NOT of reproductive potential ☐Female child – NOT of reproductive potential ☐Adult male

☐Adult female – Reproductive potential ☐Female child – Reproductive potential ☐Male child

Physician authorization #: _____ Date: _____

Pharmacy confirmation #: _____ Date: _____

(For pharmacy use only)

☐Akynzeo ☐Aloxi ☐Anzemet ☐Emend ☐Sancuso ☐Zofran ☐Other: _____			
☐Granix ☐Leukine ☐Neupogen ☐Neulasta ☐Zarxio ☐Other: _____			
☐Aranesp ☐Procrit ☐Other: _____			
☐Arixtra ☐Fragmin ☐Heparin ☐Lovenox ☐Other: _____			

* Available at select health system pharmacy locations only.

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

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *** 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.