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

Breast and Ovarian Cancers

Prescription/Pharmacy Intake Form

Pharmacy: _____
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

Breast Cancer:		**Breast Cancer:**		**Ovarian Cancer:**	
BRCA mutation	☐Positive ☐Negative	**Estrogen Receptor Status**	☐Positive ☐Negative	**BRCA mutation**	☐Positive ☐Negative
PIK2CA mutation	☐Positive ☐Negative	**HER2 Status**	☐Positive ☐Negative		
		Progesterone Receptor Status	☐Positive ☐Negative		

Is patient postmenopausal? ☐Yes ☐No

Medication	Dose/Directions/Frequency	Qty	Refills
☐Afinitor† ☐Ibrance† ☐Kisqali† ☐Kisqali Femara Co-Pack ☐Lynparza capsules* ☐Lynparza tablets* ☐Piqray ☐Talzenna ☐Tykerb† ☐Verzenio† ☐Xeloda ☐Other: _____			
†**If prescribing Afinitor:** ☐Aromasin			
†**If prescribing Ibrance:** ☐Arimidex ☐Aromasin			
†**If prescribing Kisqali:** ☐Arimidex ☐Aromasin			
†**If prescribing Tykerb:** ☐Femara			
†**If prescribing Verzenio:** ☐Arimidex ☐Aromasin			
☐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

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.