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 + PRIME

Organ Transplant

Immunosuppressants

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)**: Primary _____ Secondary _____

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

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

(Please include all supporting material including but not limited to History and Physical, Progress Notes and Recent Labs)

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

☐Heart (Z94.1) ☐Kidney (Z94.0) ☐Liver (Z94.4) ☐Lung (Z94.2) ☐Intestines (Z94.82) ☐Pancreas (Z94.83) ☐Heart/Lung (Z94.3) ☐Kidney/Pancreas (Z94.0/Z94.83) ☐Bone Marrow (Z94.81)

Organ Transplanted: _____ Date of Transplant: _____ Date of Discharge: _____

Weight: _____ ☐lb ☐kg Date: _____ Height: _____ ☐in ☐cm Date: _____

Allergies: _____

MEDICATIONS

Astagraf XL (tacrolimus ER capsule)
- ☐0.5mg _____ Qty____ Refills ___
- ☐1mg _____ Qty____ Refills ___
- ☐5mg _____ Qty____ Refills ___

Cellcept (mycophenolate)
- ☐250mg _____ Qty____ Refills ___
- ☐500mg _____ Qty____ Refills ___
- ☐200mg/ml _____ Qty____ Refills ___

Envarsus XR (tacrolimus ER tablet)
- ☐0.75mg _____ Qty____ Refills ___
- ☐1mg _____ Qty____ Refills ___
- ☐4mg _____ Qty____ Refills ___

Gengraf (cyclosporine mod)
- ☐25mg _____ Qty____ Refills ___
- ☐50mg _____ Qty____ Refills ___
- ☐100mg _____ Qty____ Refills ___
- ☐100mg/ml _____ Qty____ Refills ___

Imuran (azathioprine)
- ☐50mg _____ Qty____ Refills ___

Myfortic (mycophenolic acid)
- ☐180mg _____ Qty____ Refills ___
- ☐360mg _____ Qty____ Refills ___

Neoral (cyclosporine mod)
- ☐25mg _____ Qty____ Refills ___
- ☐100mg _____ Qty____ Refills ___
- ☐100mg/ml _____ Qty____ Refills ___

Prednisone
- ☐5mg _____ Qty ___ Refills____
- ☐10mg _____ Qty ___ Refills____
- ☐20mg _____ Qty ___ Refills____

Prograf (tacrolimus)
- ☐0.5mg _____ Qty ___ Refills____
- ☐1mg _____ Qty ___ Refills____
- ☐5mg _____ Qty ___ Refills____

Prograf Granules (tacrolimus for oral suspension)
- ☐0.2mg _____ Qty ___ Refills____
- ☐1mg _____ Qty ___ Refills____

Rapamune (sirolimus)
- ☐0.5mg _____ Qty ___ Refills____
- ☐1mg _____ Qty ___ Refills____
- ☐2mg _____ Qty ___ Refills____
- ☐1mg/ml _____ Qty ___ Refills____

Sandimmune (cyclosporine)
- ☐25mg _____ Qty ___ Refills____
- ☐100mg _____ Qty ___ Refills____
- ☐100mg/ml _____ Qty ___ Refills____

Zortress (everolimus)
- ☐0.25mg _____ Qty ___ Refills____
- ☐0.5mg _____ Qty ___ Refills____
- ☐0.75mg _____ Qty ___ Refills____
- ☐1mg _____ Qty ___ Refills____

Other:
- ☐ _____ Qty ___ Refills____

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.