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

Antifungals, Antivirals, PCP Prophylaxis/Antibiotics
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

Antifungals

Nystatin Oral Susp.
☐100,000u/ml _____ Qty____ Refills ___
Mycelex (clotrimazole troche)
☐10mg _____ Qty____ Refills ___
Diflucan (fluconazole)
☐100mg _____ Qty____ Refills ___
Other:
☐ _____ Qty____ Refills ___

Antivirals

Valcyte (valgancyclovir)
☐450mg _____ Qty____ Refills ___
Zovirax (acyclovir)
☐200mg _____ Qty____ Refills ___
☐400mg _____ Qty____ Refills ___
☐800mg _____ Qty____ Refills ___
Other:
☐ _____ Qty____ Refills ___

PCP Prophylaxis/Antibiotics

Bactrim SS (SMZ/TMP)
☐400/80mg _____ Qty ___ Refills____
Bactrim DS (SMZ/TMP)
☐800/160mg _____ Qty ___ Refills____
Dapsone
☐100mg _____ Qty ___ Refills____
Mepron Susp. (atovaquone)
☐750mg/5ml _____ Qty ___ Refills____
Zithromax (azithromycin)
☐250mg _____ Qty ___ Refills____
☐500mg _____ Qty ___ Refills____
Cipro (ciprofloxacin)
☐250mg _____ Qty ___ Refills____
☐500mg _____ Qty ___ Refills____
Levaquin (levofloxacin)
☐250mg _____ Qty ___ Refills____
☐500mg _____ Qty ___ Refills____
☐750mg _____ 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.