Oncology
Prescription &
Pharmacy Intake Form

Walgreens Specialty Pharmacy

Location	Fax	Phone
Ann Arbor	888-570-4700	Ph: 888-282-5166
Frisco	888-380-6181	Ph: 800-424-9002
Pittsburgh	877-235-9807	Ph: 877-235-9798
Portland	866-493-2546	Ph: 866-202-4014
Other	______________	

Provider Representative | **Phone** **Date Needed**

Ship to ☐Specialty Care Center ☐Patient's Home ☐Prescriber's Office ☐Other______________

PATIENT INFORMATION

Patient Name: ______________ DOB: __________ ☐ Male ☐ Female
Address: ______________
City: ______________ State: ________ Zip Code: __________
Phone # (Daytime): ______________ Phone # (Evening): ______________
E-mail Address: ______________
Insurance Provider (**Please include copy of front and back of card**): ______________
ID #: ______________ Policy/Group #: ______________ Phone #: ______________
Name of Insured: ______________ Employer: ______________
Relationship to Patient: ☐ Self ☐ Other: ______________ ☐ Patient is Eligible for Medicare
Prescription Card: ☐ Yes ☐ No Carrier: ______________ Policy/Group #: ______________

CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Patient is Currently on Therapy
(Start Date: __________)

Primary ICD-9 Code: __________
Diagnosis & Date:
____

Current Weight: __________
Date: __________
Current Height: __________
Date: __________
BSA: __________ m^2

Other Health Conditions:
____
____

Allergies:
____
____

Concomitant Medications:
____
____

PRESCRIPTION INFORMATION

Medication	Dose/Directions/Freq	Qty	Refills
☐**Afinitor®** ☐**Femara®** ☐ **Gleevec®** ☐**Hycamtin®** ☐ **Nexavar®** ☐ **Sprycel®** ☐**Sutent®** ☐**Tarceva®** ☐**Targretin®** ☐**Tasigna®** ☐ **Temodar®** ☐**Tykerb®** ☐**Votrient™** ☐ **Xalkori®** ☐ **Xeloda®** ☐**Zelboraf™** ☐ **Zytiga™** ☐**Mozobil®** ☐**Prednisone** ☐ **Dexamethasone** ☐**Other:** __________			
☐**Afinitor®** ☐**Femara®** ☐ **Gleevec®** ☐**Hycamtin®** ☐ **Nexavar®** ☐ **Sprycel®** ☐**Sutent®** ☐**Tarceva®** ☐**Targretin®** ☐**Tasigna®** ☐**Temodar®** ☐**Tykerb®** ☐**Votrient™** ☐ **Xalkori®** ☐ **Xeloda®** ☐**Zelboraf™** ☐ **Zytiga™** ☐**Mozobil®** ☐**Prednisone** ☐**Dexamethasone** ☐**Other:** __________			
☐**Revlimid®**			

RevAssist MD Auth #: ______________ Date: __________
☐Adult Female - NOT of Childbearing Potential ☐Adult Female - Childbearing Potential ☐Adult Male
☐ Female Child - NOT of Childbearing Potential ☐Female Child - Childbearing Potential ☐Male Child

Medication	Dose/Directions/Freq	Qty	Refills
☐**Thalomid®**			

Thalomid *STEPS* Program MD Auth #: ______________ Date: __________

PRESCRIBER INFORMATION

Prescriber's Name: ______________ Practice/Facility Name: ______________
Address: ______________ Office Contact: ______________
City: ______________ State: ________ Zip Code: __________
Phone #: ______________ Fax: ______________ Best Time to Call: ______________
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 to prohibit substitution: ______________
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: ______________ Date: __________

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.
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