Referral Tips

E-Prescribe Referrals

AllianceRx Walgreens Pharmacy is helping to make prescribing easier and more efficient. E-prescribing can reduce the wait between the time a prescription is written and when the patient actually receives the medication. It also can effectively reduce the number of prescription errors attributable to hard-to-read handwriting or illegible faxes.

Refer prescriptions to AllianceRx Walgreens Pharmacy

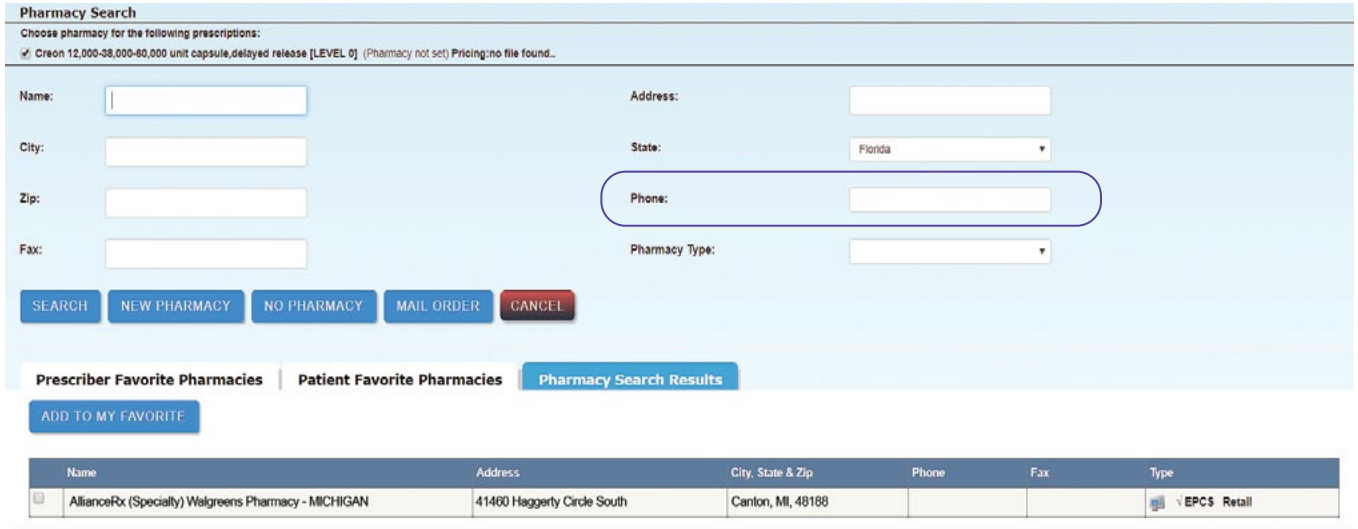
Address	Phone #	NCPDP #	Fax #	E-Prescribing Name
AllianceRx Walgreens Pharmacy 10530 John W. Elliott Drive, Suite 100 Frisco, TX 75033	800-424-9002	4591055	800-874-9179	AllianceRx (Specialty) Walgreens Pharmacy - TEXAS

Easy Referrals

To find AllianceRx Walgreens Pharmacy in your ERx system, please try the following:

1. Search by **phone** or NCPDP number
2. If you are unable to locate us, you can:
   - Reach us by calling 855-244-2555
   - Ask your system administrator to refresh the ERx system
3. Once you find AllianceRx Walgreens Pharmacy in your system, add us to your favorites

E-Prescribe Example



E-prescribe example courtesy of RxNT.

See reverse for information on faxed referrals

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Fax Referrals

Fill out the referral form with patient information, clinical assessment and medication details. Fax the referral to the number below.

Address	Phone #	Fax #
AllianceRx Walgreens Pharmacy 10530 John W. Elliott Drive, Suite 100 Frisco, TX 75033	800-424-9002	800-874-9179

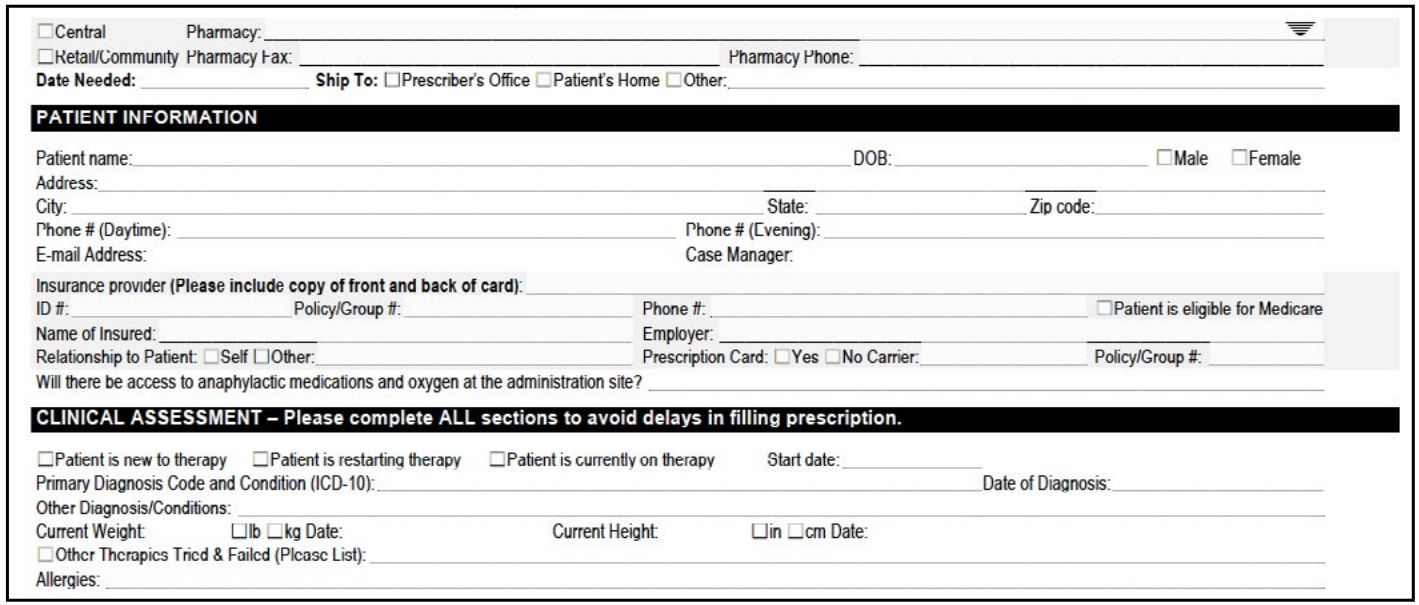
Helpful Tips To Hasten the Process

REMEMBER to include the true date by which the patient needs the medication in hand

DO NOT write "urgent" or "stat," as neither is an applicable date, and entering either will cause delays in your patient receiving medication

REMEMBER to fill out the ICD-10 code carefully, as many pharma programs require it, as well as diagnosis, in order to ensure that a patient will be eligible to apply for assistance

REMEMBER to include the patient's current weight, as it may impact medication dosing



☐Central Pharmacy: _____

☐Retail/Community 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): _____

E-mail Address: _____ Case Manager: _____

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

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

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

Will there be access to anaphylactic medications and oxygen at the administration site? _____

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

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

Primary Diagnosis Code and Condition (ICD-10): _____ Date of Diagnosis: _____

Other Diagnosis/Conditions: _____

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

☐Other Therapies Tried & Failed (Please List): _____

Allergies: _____

Image above only captures part of the referral form. For the full form, as well as for disease- and drug-specific forms, please visit alliancerxwp.com/hcp

Fax the completed referral form along with the following documentation:

- Copy of each side of the patient's insurance card
- Copies of clinical information for patient, including lab values
- Chart notes from the patient's last two visits

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