Referral Tips

E-prescribe referrals

AllianceRx Walgreens Prime 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 Prime

Address	Phone #	NCPDP #	Fax #	E-Prescribing Name
AllianceRx Walgreens Prime 9775 SW Gemini Drive Suite 1 Beaverton, OR 97008	866-202-4014	3842944	866-579-4546	ALLIANCERX WALGREENS PRIME-SPEC-OR

Easy referrals

To find AllianceRx Walgreens Prime 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:
  - Still reach us by calling 855-244-2555
  - Ask your system administrator to refresh the ERx system

3. Once you find AllianceRx Walgreens Prime in your system, add us to your favorites

E-prescribe example

E-prescribe example courtesy of RxNT.

See reverse for information on faxed referrals.

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 Prime 9775 SW Gemini Drive Suite 1 Beaverton, OR 97008	866-202-4014	866-579-4546

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

allianceRx *Walgreens* + PRIME