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 not a prescription. Please submit prescriptions electronically or via fax along with this form.

Walgreens | allianceRx Walgreens + PRIME

Clinical Data by Cancer Type

☐Central Pharmacy: _____

☐Retail/Community Pharmacy Fax: _____ Pharmacy Phone: _____

List of medications ordered **(this form is not a prescription)**: _____

Date Needed By: _____

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)**: _____

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

Name of Insured: _____ Employer: _____

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

ICD-10 code: _____ ICD-10 description: _____

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

Treatment history (or attach clinical notes reflecting history):

Please indicate the documents(s) attached:

☐Failed therapies ☐Recent laboratory results ☐Recent pathology report ☐Recent office notes ☐Copy of front and back of insurance card

Weight: _____ ☐lb ☐kg Date: _____ Height: _____ ☐in ☐cm Date: _____ BSA: _____ m^2

Allergies: _____

CANCER TYPES

Acute Lymphoblastic Leukemia (ALL):

Philadelphia chromosome status	☐Positive ☐Negative ☐N/A

Acute Myeloid Leukemia (AML):

FLT3 mutation	☐Positive ☐Negative ☐N/A
IDH2 mutation	☐Positive ☐Negative ☐N/A

Breast & Ovarian Cancer:

BRCA mutation	☐Positive ☐Negative ☐N/A
PIK3CA mutation	☐Positive ☐Negative ☐N/A
Estrogen Receptor status	☐Positive ☐Negative ☐N/A
HER2 status	☐Positive ☐Negative ☐N/A
Progesterone Receptor status	☐Positive ☐Negative ☐N/A

Is patient postmenopausal? ☐Yes ☐No

Chronic Lymphocytic Leukemia (CLL):

17p deletion	☐Positive ☐Negative ☐N/A

Chronic Myeloid Leukemia (CML):

Philadelphia chromosome status	☐Positive ☐Negative ☐N/A

Colorectal Cancer:

KRAS Wild Type	☐Positive ☐Negative ☐N/A

Lung Cancer:

ALK gene rearrangement	☐Positive ☐Negative ☐N/A
BRAF mutation, V600E	☐Positive ☐Negative ☐N/A
EGFR, exon 19 deletion	☐Positive ☐Negative ☐N/A
EGFR, exon 21 substitution	☐Positive ☐Negative ☐N/A
EGFR, T790M mutation	☐Positive ☐Negative ☐N/A
ROS1 gene alteration	☐Positive ☐Negative ☐N/A

Melanoma:

BRAF mutation, V600E	☐Positive ☐Negative ☐N/A
BRAF mutation, V600K	☐Positive ☐Negative ☐N/A

Surgery date: _____

Myelodysplastic Syndrome (MDS) / Myeloproliferative diseases or Neoplasms:

Deletion 5q	☐Positive ☐Negative ☐N/A
JAK2 status	☐Positive ☐Negative ☐N/A
PDGF Receptor Gene status	☐Positive ☐Negative ☐N/A

Other:

D816V c-Kit	☐Positive ☐Negative ☐N/A
FIP1L1-PDGF receptor alpha fusion kinase	☐Positive ☐Negative ☐N/A
Kit (CD117)	☐Positive ☐Negative ☐N/A
NTRK Gene Fusion	☐Positive ☐Negative ☐N/A

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email (optional): _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

I certify that the above information is accurate to the best of my knowledge.

Prescriber or Authorized Healthcare Provider Signature Required: _____ Date: _____