PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Eulexin™ (flutamide) 125mg capsules

PRESCRIPTION & ENROLLMENT FORM

☐ New patient ☐ Current patient

Note: This form is intended for prescriber use only. If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

Patient name ______ Date of birth ______ ☐ Male ☐ Female

Street address ______ City ______ State ______ Zip ______

Parent/guardian (if applicable) ______ ☐ Principle contact

Home phone ______ Work phone ______ Cell phone ______ Evening phone ______

E-mail address ______

Insurance company name ______ Insurance company phone # ______

Insured name ______ Insured employer ______

Relationship to patient ______ Identification # ______ Policy/group # ______

Prescription card ☐ No ☐ Yes If yes, carrier ______ Policy # ______ Group # ______

Eligible for Medicare? ☐ No ☐ Yes Eligible for Medicaid? ☐ No ☐ Yes

PRESCRIBER INFORMATION

Date ______ Time ______

Prescriber name ______ Prescriber practice title ______

Street address ______ City ______ State ______ Zip ______

Phone ______ Fax ______

License # ______ DEA # ______ Physician Medicaid UPIN # ______ NPI# ______

MD specialty ______ For ARNP, NP, and PA, collaborative physician agreement with: ______

CLINICAL INFORMATION

ICD-10 code: ______ Secondary ICD-10: ______ Other ______

Other lab tests completed: ______ Date: ______

Patient weight: ______ ☐ NKDA ☐ Known drug allergies ______

PRESCRIBING INFORMATION

Eulexin (flutamide) 125mg capsules

☐ Recommended dosage: 250mg (2 capsules) by mouth three times a day at 8 hour intervals

☐ Other dosage: ______

Deliver product to: Patient home ☐ Yes ☐ No Other ☐ Yes ☐ No Ship to address: ______

EULEXIN QUICKSTART PROGRAM

If there is a delay in verifying insurance coverage, I authorize the Eulexin QuickStart Program pharmacy to dispense a free initial supply of Eulexin to eligible patients.
Terms and Conditions apply.

Eulexin (flutamide) 125mg capsules

Dosage: ______

Deliver product to: ☐ Patient home ☐ Other

Ship to address: ______

PRESCRIBER SIGNATURE

By signing below, I certify that the prescribed therapy is medically necessary.

Physician printed name ______

Physician signature ______ Date ______ (No stamps) (Dispense as written)

Physician signature ______ Date ______ (No stamps) (Substitutions permitted)

This prescription is valid only if transmitted by means of a facsimile machine directly from the prescriber's office or place of practice.

Phone: 866-202-4888 Fax: 888-440-6703

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *****

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. Drug names are the property of their respective owners.

©2022 AllianceRx Walgreens Pharmacy All rights reserved. 062422

allianceRx

Walgreens Pharmacy

Phone: 866-202-4888
Fax: 888-440-6703