

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY TO THE PITTSBURGH LOCATION AND INCLUDE HEARTBEAT PROGRAM AND CANCER DIAGNOSIS IN PRESCRIPTION COMMENTS.

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

allianceRx

Walgreens Pharmacy

130 Enterprise Dr., Pittsburgh, PA 15275
Phone: 888-347-3415 Fax: 888-347-3417

Prescription/Pharmacy Intake Form

For office use only

Clinic Name: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Today's Date: _____ Anticipated Start Date (REQUIRED): _____ Ship to: MDO Patient

Name: _____ DOB: _____ Allergies: _____

Address: _____

Home: _____ Work: _____ Cell: _____

Cycle Type: Fertility Preservation Insurance : Copy of card (front and back) ICD-10 _____ Cycle#: _____

ICD-10: _____ AMH: _____ ng/ml (recommended, but optional)



heartbeat

PRESERVING THE FUTURE

Eligible Medications**

Fyremadel 250 mcg/0.5mL Injection _____ Qty
Sig.: _____ (= ___ days) _____ Refills

Menopur 75 International Units IM SC _____ Qty (Vials)
 3ml 22g 1 1/2" syringes/needles # _____ g _____ " needles
Sig.: _____ (= ___ days) _____ Refills

Novarel 5,000 International Units IM SC _____ Qty (Vials)
 3ml 22g 1 1/2" syringes/needles # _____ g _____ " needles
Sig.: _____ (= ___ days) _____ Refills

****Please note, ONLY the medications listed above are eligible for the Heart Beat Program. Additional or ancillary medications will be processed thru insurance and/or require an out-of-pocket expense****

Non-Eligible for Heart Beat Program**

leuprolide acetate 1mg/0.2ml – 2 week kit _____ Qty (Kits)
Sig.: _____ (= ___ days) _____ Refills

Leuprolide acetate Trigger
 1 MG/0.2mL _____ Qty (PFS)
 2 MG/0.4mL _____ Qty (PFS)
 4 MG/0.8mL _____ Qty (PFS)
Sig.: _____ (= ___ days) _____ Refills

Girelix (Brand) 250 mcg/0.5mL Injection _____ Qty
Sig.: _____ (= ___ days) _____ Refills

Follistim AQ Cartridge Follistim Pen
 300 International Units _____ Qty
 600 International Units _____ Qty
 900 International Units _____ Qty
Sig.: _____ (= ___ days) _____ Refills

Letrozole 2.5mg _____ Qty (Tabs)
Sig.: _____ (= ___ days) _____ Refills

Clomiphene Citrate 50mg _____ Qty (Tabs)
Sig.: _____ (= ___ days) _____ Refills

Other: _____ Qty
Sig.: _____ (= ___ days) _____ Refills

Other: _____ Qty
Sig.: _____ (= ___ days) _____ Refills

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

Prescriber's name: _____

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 after their signature.

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 on one of the lines below.

Dispense as written

Substitution permitted

Date

Certain restrictions may apply. Federal healthcare program beneficiaries, including but not limited to State Medicaid and State Medicaid managed care recipients, as well as residents of Massachusetts, New Jersey and Arkansas are ineligible for the program.

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

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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