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

Walgreens | allianceRx Walgreens + PRIME

Lung Cancer
Prescription/Pharmacy Intake Form

☐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): _____
Insurance provider **(Please include copy of front and back of card)**: _____
ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

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

☐Patient is new to therapy ☐Patient is currently on therapy Start date: _____
ICD-10 code: _____ ICD-10 description: _____
Weight: _____ ☐lb ☐kg Date: _____ Height: _____ ☐in ☐cm Date: _____ BSA: _____ m^2
Allergies: _____
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

ALK gene rearrangement	☐Positive ☐Negative	**EGFR, exon 21 substitution**	☐Positive ☐Negative
BRAF mutation, V600E	☐Positive ☐Negative	**EGFR, T790M mutation**	☐Positive ☐Negative
EGFR, exon 19 deletion	☐Positive ☐Negative	**ROS1 Gene alteration**	☐Positive ☐Negative

☐Alecensa ☐Iressa* ☐Tagrisso* ☐Xalkori ☐Other: _____	☐Gilotrif* ☐Lorbrena ☐Tarceva ☐Zykadia	☐Hycamtin ☐Rozlytrek ☐Vizimpro			
☐Mekinist					
☐Tafinlar					
☐Akynzeo ☐Emend ☐Other: _____	☐Aloxi ☐Sancuso	☐Anzemet ☐Zofran			
☐Granix ☐Neulasta ☐Other: _____	☐Leukine ☐Zarxio	☐Neupogen			
☐Aranesp ☐Other: _____	☐Procrit				
☐Arixtra ☐Heparin ☐Other: _____	☐Fragmin ☐Lovenox				

* Available at select health system pharmacy locations only.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____
Address: _____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax: _____
Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax
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

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.