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

Organ Transplant

Gastrointestinal and Miscellaneous

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): Primary _____ Secondary _____

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

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

(Please include all supporting material including but not limited to History and Physical, Progress Notes and Recent Labs)

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

☐Heart (Z94.1) ☐Kidney (Z94.0) ☐Liver (Z94.4) ☐Lung (Z94.2) ☐Intestines (Z94.82) ☐Pancreas (Z94.83) ☐Heart/Lung (Z94.3) ☐Kidney/Pancreas (Z94.0/Z94.83) ☐Bone Marrow (Z94.81)

Organ Transplanted: _____ Date of Transplant: _____ Date of Discharge: _____

Weight: _____ ☐lb ☐kg Date: _____ Height: _____ ☐in ☐cm Date: _____

Allergies: _____

MEDICATIONS

Gastrointestinal

Pepcid (famotidine)
- ☐20mg _____ Qty ____ Refills ____
- ☐40mg _____ Qty ____ Refills ____

Prevacid (lansoprazole)
- ☐30mg _____ Qty ____ Refills ____

Prilosec (omeprazole)
- ☐20mg _____ Qty ____ Refills ____
- ☐40mg _____ Qty ____ Refills ____

Protonix (pantoprazole)
- ☐40mg _____ Qty ____ Refills ____

Zantac (ranitidine)
- ☐150mg _____ Qty ____ Refills ____
- ☐300mg _____ Qty ____ Refills ____

Other:
- ☐ _____ Qty ____ Refills ____

Miscellaneous

Aspirin
- ☐81mg _____ Qty ____ Refills ____
- ☐325mg _____ Qty ____ Refills ____

Hydrochlorothiazide
- ☐25mg _____ Qty ____ Refills ____
- ☐50mg _____ Qty ____ Refills ____

Lasix (furosemide)
- ☐20mg _____ Qty ____ Refills ____
- ☐40mg _____ Qty ____ Refills ____
- ☐80mg _____ Qty ____ Refills ____

Norvasc (amlodipine)
- ☐5mg _____ Qty ____ Refills ____
- ☐10mg _____ Qty ____ Refills ____

Other:
- ☐ _____ Qty ____ Refills ____

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