Oncology Self Injectables

Prescription/Pharmacy Intake Form

Fax: 866-406-4215 Phone: 866-406-4209

MEDICA.

PATIENT INFORMATION ☐ **NEW TO THERAPY** ☐ **THERAPY CONTINUATION**

Name: _____ ☐ M ☐ F

Address: _____

City: _____ State: _____ ZIP Code: _____

DOB: _____ Patient Weight: _____ Patient Height: _____

Allergies: _____

Deliver medication to: ☐ **Patient's home** ☐ **Prescriber's office** **DATE NEEDED:** _____

Daytime Phone w/Area Code: _____

Evening Phone w/Area Code: _____

Cell Phone w/Area Code: _____

PCP Name: _____

PCP Phone w/ Area Code: _____

Email: _____

INSURANCE INFORMATION (Please include copy of front and back of insurance card if possible):

Provider/Plan: _____ Phone w/Area Code: _____

Patient's ID #: _____ Patient's Group #: _____

Policyholder's Name (if not patient): _____

Secondary Insurance: _____ Phone w/Area Code: _____

Patient's ID #: _____ Patient's Group #: _____

Policyholder's Name (if not patient): _____

CLINICAL CRITERIA **REQUIRED** Please check all that apply.

ICD-9 and Condition: ☐ _____._____ ☐ Other (explain): _____

Rx INFORMATION

Medication	Form	Strength	Qty	Dose	Directions/Freq	Refills
Arixtra®						
Fragmin®						
Intron® A						
Lovenox®						
Neulasta®						
Neupogen®						

Nursing Orders:

RN visit x1 to teach patient or caregiver self administration of _____. If first dose, implement physician orders for "Drug Related Adverse Reactions."

Note: For first dose, include "Drug Related Adverse Reactions" form signed by physician.

Print Prescriber's Name: _____ Office Contact: _____

Practice Name: _____ State License #: _____

UPIN: _____ NPI: _____ DEA # _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone w/Area Code: _____ Fax w/Area Code: _____

☐ **Substitution Permissible.*** In order for a brand-name product to be dispensed, the prescriber must handwrite BRAND NECESSARY or BRAND MEDICALLY NECESSARY in the space below.

_____

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: _____ Date: _____

CONFIDENTIAL HEALTH INFORMATION: Health care information is personal information related to a person's health care. 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. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

Drug names are the property of their respective owners.

©2008 Walgreen Co. All rights reserved. SP9067A-0908