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).

Walgreens Specialty Pharmacy

# Universal

Prescription/Pharmacy Intake Form

***Select one of our Central Pharmacy numbers from the drop-downs below, or type a Retail/Community Pharmacy number in the blank space provided

**Rx FAX:** **Rx Phone:**

**Provider Representative** | **Phone** **Date Needed** **Ship to** ☐Specialty Care Center ☐Patient's Home ☐Prescriber's Office ☐Other_____

## PATIENT INFORMATION

Patient Name: _____ DOB:_____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (Daytime):_____ Phone # (Evening):_____

E-mail Address: _____

Insurance Provider (**Please include copy of front and back of card**):_____

ID #:_____ Policy/Group #:_____ Phone #:_____

Name of Insured: _____ Employer:_____

Relationship to Patient: ☐ Self ☐ Other:_____ ☐ Patient is Eligible for Medicare

Prescription Card: ☐ Yes ☐ No Carrier:_____ Policy/Group #:_____

## CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Patient is Restarting Therapy
☐ Patient is Currently on Therapy
(Start Date: _____)

Primary Code T Condition: _____

Allergies: _____

Current Weight: _____(kg / lbs) Current Height: _____(cm / in)

## PRESCRIPTION INFORMATION

| Medication | Form | Strength | Quantity | Directions/Frequency | Dose | Refills |
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## PRESCRIBER INFORMATION

Prescriber's Name:_____ Practice/Facility Name:_____

Address:_____ Contact:_____

City: _____ State: _____ Zip Code:_____

Phone #: _____ Fax: _____ Best Time to Call:_____

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 to prohibit substitution: _____

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: _____

Secondary Signature Optional: _____ Date: _____