

Ophthalmic Prescription/Pharmacy Intake Form

AllianceRx Walgreens Prime

 Phone: **888-347-3416**

 Fax: **866-586-7804**
PATIENT INFORMATION
 NEW TO THERAPY
 THERAPY CONTINUATION

 Patient's Name: _____ M F

Daytime Phone: (____) _____

Patient's Social Security Number: _____ DOB: _____

Evening Phone: (____) _____

Patient's Address: _____

Cell Phone: (____) _____

City/State/Zip: _____

PCP Name: _____

 DELIVER MEDICATION TO PHYSICIAN'S OFFICE

PCP Phone: _____

 DELIVER MEDICATION TO Other Phone Number: _____

 Patient's Scheduled Appointment Date: _____ Date Delivery Needed: _____ Delivery Day Preference: T W Th F

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

Provider/Plan: _____

Phone Number: _____

Patient's I.D. Number: _____

Patient's Group Number: _____

Policyholder's Name (if not patient): _____

DOB: _____ Social Security Number: _____

Secondary Insurance: _____

Phone Number: _____

Patient's I.D. Number: _____

Patient's Group Number: _____

Policyholder's Name (if not patient): _____

DOB: _____ Social Security Number: _____

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

Diagnosis Code: _____

Affected eye:
 Left eye

 Right eye

 Both eyes

Medication	Form	Strength/Dose	Qty	Directions/Frequency	Refills
Eylea [®]	SDV	<input type="checkbox"/> 2mg/0.05ml			
Jetrea [®]	SDV	<input type="checkbox"/> 1.25mg/ml			
Iluvien [®]	Implant	<input type="checkbox"/> 0.19 mg			
Lucentis [®]	Vial	<input type="checkbox"/> 0.3mg/0.05ml* <input type="checkbox"/> 0.5mg/0.05ml			
	PFS	<input type="checkbox"/> 0.5mg/0.05ml			
Ozurdex [®]	Implant	<input type="checkbox"/> 0.7mg			
Triesence [®]	Vial	<input type="checkbox"/> 40mg/ml			
Visudyne [®]	Vial	<input type="checkbox"/> 15mg			

* Only for Certain diagnosis(Diabetic Macular Edema) E11.311

Prescriber's Name: _____ Office Contact: _____

Practice Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

State License # _____ DEA# _____ Physician NPI # _____

Prescriber's Signature: _____ Date: _____

 Substitution Permissible M.D.* In order for a brand name product to be dispensed, the prescriber must handwrite 'BRAND NECESSARY' or "BRAND MEDICALLY NECESSARY" in the space provided _____

*as appropriate

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