Walgreens A Network of Specialty Pharmacy Solutions

Central • Retail • Community

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: Canton, MI 888-570-4700 **Rx Phone:** Canton, MI 888-282-5166

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 ICD-9 Code and Condition: _____

Allergies: _____

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

PRESCRIPTION INFORMATION

Medication	Form	Strength	Quantity	Directions/Frequency	Dose	Refills

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: _____