PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY TO THE PITTSBURGH LOCATION AND INCLUDE HEARTBEAT PROGRAM AND CANCER DIAGNOSIS IN PRESCRIPTION COMMENTS.

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).**

allianceRx
Walgreens + PRIME

130 Enterprise Dr., Pittsburgh, PA 15275
Phone: 888-347-3415 Fax: 888-347-3417

Prescription/Pharmacy Intake Form
For office use only

Clinic Name: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____

Today's Date: _____ **Anticipated Start Date (REQUIRED):** _____ **Ship to:** ☐ MDO ☐ Patient
Name: _____ **DOB:** _____ **Allergies:** _____
Address: _____
Home: _____ **Work:** _____ **Cell:** _____
Cycle Type: ☐ Fertility Preservation **Insurance** ☐ : Copy of card (front and back) **ICD-10** _____ **Cycle#:** _____
☐ ICD-10: _____

heartbeat
PRESERVING THE FUTURE

Eligible Medications**

☐ Menopur 75 International Units ____ Qty (Vials)
☐ 3ml 22g 1 ½" syringes/needles #_____ _____g _____" needles
Sig.: _____ (= ___ days) ____ Refills

☐ Novarel 5,000 International Units ____ Qty (Vials)
☐ 3ml 22g 1 ½" syringes/needles #_____ _____g _____" needles
Sig.: _____ (= ___ days) ____ Refills

****Please note, ONLY the medications listed above are eligible for the Heart Beat Program. Additional or ancillary medications will be processed thru insurance and/or require an out-of-pocket expense****

Non-Eligible for Heart Beat Program**

☐ leuprolide acetate 1mg/0.2ml – 2 week kit ____ Qty (Kits)
Sig.: _____ (= ___ days) ____ Refills

☐ Leuprolide acetate Trigger
☐ 1 MG/0.2mL ____ Qty (Vials)
☐ 2 MG/0.4mL ____ Qty (Vials)
☐ 4 MG/0.8mL ____ Qty (Vials)
Sig.: _____ (= ___ days) ____ Refills

☐ HCG 10,000 International Units ____ Qty (Vials)
☐ 3ml 22g 1 ½" syringes/needles #_____ _____g _____" needles
Sig.: _____ (= ___ days) ____ Refills

☐ Letrozole 2.5mg ____ Qty (Tabs)
Sig.: _____ (= ___ days) ____ Refills

☐ Tamoxifen
☐ 10mg ____ Qty (Tabs)
☐ 20mg ____ Qty (Tabs)
Sig.: _____ (= ___ days) ____ Refills

☐ Clomiphene Citrate 50mg ____ Qty (Tabs)
Sig.: _____ (= ___ days) ____ Refills

☐ Other: _____ ____ Qty
Sig.: _____ (= ___ days) ____ Refills

☐ Other: _____ ____ Qty
Sig.: _____ (= ___ days) ____ Refills

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

Prescriber's name: _____
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

Certain restrictions may apply. Federal healthcare program beneficiaries, including but not limited to State Medicaid and State Medicaid managed care recipients, as well as residents of Massachusetts, New Jersey and Arkansas are ineligible for the program.

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.