

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#: \_\_\_\_\_



## heartbeat

PRESERVING THE FUTURE

**Eligible Medications\*\***

Menopur 75 International Units \_\_\_\_\_ Qty (Vials)

3ml 22g 1 1/2" syringes/needles # \_\_\_\_\_ g \_\_\_\_\_" needles

Sig.: \_\_\_\_\_ (= \_\_\_\_\_ days) \_\_\_\_\_ Refills

Novarel 5,000 International Units \_\_\_\_\_ Qty (Vials)

3ml 22g 1 1/2" 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 1/2" 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.

The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.