Reminder:
Try Our Mail-Order Prescription Service

A great way to help your **IEHP DualChoice Members** stay safely at home is to encourage them to register for our prescription mail order service at: https://www.alliancerxwp.com/home-delivery.

- After your patient signs up for the mail order service and requests prescriptions, you can send them by eRx or fax to AllianceRx Walgreens Prime for home delivery.
    - Fax: **1-800-332-9581** *Print out/ fill out and send the fax form (downloadable PDF form posted).*
    - E-Prescribe: AllianceRx Walgreens Prime#03397 in Tempe, AZ.
    - eRx: AllianceRx Walgreens.
- To learn more, call AllianceRx Walgreens Prime at **1-800-345-1985.**

allianceRx Walgreens + PRIME

Home Delivery Prescriber Fax Form

Prescription Drug Plan: _____

THIS FORM MUST BE FAXED FROM A PRESCRIBER'S OFFICE TO BE VALID.

PATIENT SECTION

Patient: To have your order processed, you must be registered with AllianceRx Walgreens Prime. **You can register online at alliancerxwp.com/home-delivery.**

IMPORTANT NOTICE: Generic equivalents are less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. ❑ I do not accept a generic equivalent.

After you are registered, please print your member ID number, BIN, and PCN listed on your ID card, and your phone number and address in the space below. Give this form to your prescriber to complete and fax to us.

Member ID Number *(located on card)* _____ BIN *(located on card)* _____ PCN *(located on card)* _____

Patient Address _____

City _____ State ____ ZIP Code _____ Patient Phone _____ – _____ – _____

PRESCRIBER SECTION

Prescriber: Fax this completed form to **AllianceRx Walgreens Prime** at **800-332-9581.**

Transmit eRx prescriptions to: AllianceRx Walgreens Prime-MAIL-AZ
Mail Order Store #03397 | 8350 S River Pkwy, Tempe, AZ 85284-2615

Patient Name _____ **DOB [MM/DD/YYYY]** _____

	Medication	Strength	Directions	Qty.	# of Refills
Rx 1					
	Medication	**Strength**	**Directions**	**Qty.**	**# of Refills**
Rx 2					

Your signature and date are required. Most prescription drug plans allow up to a 3 month supply with three refills. NOT VALID FOR CII PRESCRIPTIONS. DATE: _____

Prescriber Signature _____

❑ Dispense as written (brand is medically neccessary) ❑ Generic substitution permitted

NPI#: _____ DEA#: _____
Required for Controlled Substances

Prescriber Name (Please print) _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ – _____ – _____ Prescriber Fax: _____ – _____ – _____

❑ Check box if this is a new fax number