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1-844-259-1891

Patient Information

☐ New Patient ☐ Current Patient

Patient's Name

First ________ Last ________ MI ________

☐ Male ☐ Female

Last 4 digits of SSN ________ Date of Birth ________

Street Address ________

City ________ State ________ ZIP ________

Preferred Phone ________ ☐ Landline ☐ Mobile

Alternate Phone ________ ☐ Landline ☐ Mobile

Preferred Method of Contact ☐ Call ☐ Text

Email Address ________

Patient's Primary Language ☐ English ☐ Other If other, please specify ________

Parent/Guardian Name (if under 18) ________

Home Phone ________ Cell Phone ________

Email Address ________

Alternate Caregiver/Contact ________

☐ OK to speak to/leave message with alternate caregiver/contact

Home Phone ________ Cell Phone ________

Email Address ________

PLEASE ATTACH COPY OF FRONT AND BACK OF PATIENT'S INSURANCE CARD

Prescriber Information

Date Prescription Needed ________

☐ Ship to Office ☐ Patient Pickup at Retail ☐ Ship to Home

Office Hours to Receive Shipment of Medication ________

Office Contact and Title ________

Office Contact Phone ________

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Patient's Name

First ______________________ Last ______________________ MI ________

Date of Birth ______________

Primary ICD-10 code ______________ Has the patient been on this therapy before? ☐ Yes ☐ No

Height ________ cm Weight ________ kg Date Recorded ______________

TB Test Results and Date ______________________

Has Hepatitis B been ruled out? ☐ Yes ☐ No Date ______________

If No, has treatment been initiated? ☐ Yes ☐ No

☐ New Therapy Induction ☐ Therapy Change

Other Therapies Tried and Failed

☐ Corticosteroids Date ______________

☐ Methotrexate Date ______________

☐ Azathioprine/6MP Date ______________

☐ Sulfasalazine/Mesalamine Date ______________

☐ Cyclosporine Date ______________

☐ Other Biologics ______________ Date ______________

☐ Other ______________

Additional justification for drug ______________

☐ NKDA ☐ Known drug allergies ______________

Concurrent Medications ______________

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Humira (adalimumab) ***Adult***	**Starter:** **CITRATE FREE** ☐ 80mg/0.8mL pen starter kit (3 Pens)	**Starter:** Inject 160mg (contents of 2 devices) subcutaneously on day 1 followed by 80mg subcutaneously 2 weeks later on day 15. Then start maintenance dose on day 29.	**Starter:** Qty: 1 kit Refills: 0
	Maintenance: **CITRATE FREE** ☐ 40mg/0.4mL pen ☐ 40mg/0.4mL prefilled syringe **ORIGINAL FORMULATION** ☐ 40mg/0.8mL pen ☐ 40mg/0.8mL prefilled syringe	**Maintenance:** ☐ Inject 40mg subcutaneously every other week. ☐ Inject 40mg subcutaneously every week.	**Maintenance:** Qty: ☐ 1 kit (2 devices) ☐ 2 kits (4 devices) ☐ 3 kits (6 devices) ☐ 6 kits (12 devices) Refills: ________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Humira (adalimumab) ***Pediatric*** Patient weight __________ kg	**Starter:** **CITRATE FREE** ☐ 80mg/0.8mL prefilled syringe starter kit (3 syringes) ☐ 80mg/0.8mL and 40mg/0.4mL syringe starter kit	**Starter:** ☐ Inject 160mg (contents of 2 devices) subcutaneously on day 1 followed by 80mg subcutaneously 2 weeks later on day 15. Then start maintenance dose on day 29. ☐ Inject 80mg subcutaneously on day 1 followed by 40mg subcutaneously 2 weeks later on day 15. Then start maintenance dose on day 29.	**Starter:** Qty: 1 kit Refills: 0
	Maintenance: **CITRATE FREE** ☐ 40mg/0.4mL pen ☐ 40mg/0.4mL prefilled syringe ☐ 20mg/0.2mL prefilled syringe **ORIGINAL FORMULATION** ☐ 40mg/0.8mL pen ☐ 40mg/0.8mL prefilled syringe	**Maintenance:** ☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week ☐ Inject 20mg subcutaneously weekly ☐ Inject 40mg subcutaneously weekly	**Maintenance:** Qty: ☐ 1 kit (2 devices) ☐ 2 kits (4 devices) ☐ 3 kits (6 devices) ☐ 6 kits (12 devices) ☐ Other __________ Refills: __________
☐ Simponi (golimumab)	☐ 100mg/mL prefilled syringe ☐ 100mg/mL SmartJect auto-injector	**Starter:** ☐ Inject 200mg subcutaneously at week 0, followed by100mg subcutaneously at week 2. Then start maintenance dose at week 6.	**Starter:** Qty: 3 devices Refills: 0
		Maintenance: ☐ Inject 100mg subcutaneously every 4 weeks	**Maintenance:** Qty: ☐ 1 device ☐ 3 devices Refills: __________
☐ Stelara (ustekinumab) Patient weight __________ kg	**Starter:** ☐ ≤55kg = 260mg vial ☐ >55kg to 85kg = 390mg vial ☐ >85kg = 520mg vial	**Starter:** ☐ Infuse 260mg over at least 1 hour intravenously as a single dose. Begin maintenance dose 8 weeks after the IV induction. ☐ Infuse 390mg over at least 1 hour intravenously as a single dose. Begin maintenance dose 8 weeks after the IV induction. ☐ Infuse 520mg over at least 1 hour intravenously as a single dose. Begin maintenance dose 8 weeks after the IV induction.	**Starter:** Qty: ☐ 2 vials (260mg) ☐ 3 vials (390mg) ☐ 4 vials (520mg) Refills: 0
	Maintenance: ☐ 90mg/ml prefilled syringe	**Maintenance:** ☐ Inject 90mg/mL subcutaneously every 8 weeks	**Maintenance:** ☐ 1 prefilled syringe Refills: __________
☐ Cimzia (certolizumab pegol)	**Starter:** ☐ 200mg/mL prefilled syringes (1 kit = 6 syringes, 3 doses)	**Starter:** ☐ Inject the contents of 2 syringes (400mg) subcutaneously at weeks 0, 2, and 4	**Starter:** ☐ 1 kit Refills: 0
	Maintenance: ☐ 200mg/mL prefilled syringes (total dose = 400mg)	**Maintenance:** ☐ Inject the contents of 2 syringes (400mg) subcutaneously every 4 weeks	**Maintenance:** ☐ 2 syringes ☐ 6 syringes Refills: __________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Remicade (infliximab) OR biosimilar ☐ Avsola (infliximab-axxq) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) Patient weight ________ kg	100mg vial	**Starter:** ☐ Infuse_____mg (5mg/kg) intravenously at week 0, 2, and 6, then every 8 weeks thereafter	**Starter:** Qty: _____vial(s) Refills: 0
		Maintenance: ☐ Infuse_____mg (5mg/kg) intravenously every 8 weeks ☐ Infuse_____mg (10mg/kg) intravenously every 8 weeks	**Maintenance:** Qty: _____vial(s) Refills: ________
☐ Entyvio (vedolizumab)	300mg vial	**Starter:** ☐ Infuse 300mg intravenously at weeks 0, 2, and 6, then every 8 weeks thereafter	**Starter:** Qty: _____vial(s) Refills: 0
		Maintenance: ☐ Infuse 300mg intravenously every 8 weeks	**Maintenance:** Qty: _____vial(s) Refills: ________
☐ Rinvoq (upadacitnib)	**Starter:** ☐ 45mg tablet	**Starter:** ☐ Take 45mg by mouth once daily for 8 weeks ☐ Take 45mg by mouth once daily for 12 weeks	**Starter:** ☐ 28 tablets ☐ 56 tablets Refills: 0
	Maintenance: ☐ 15mg tablet ☐ 30mg tablet	**Maintenance:** ☐ Take 15mg by mouth once daily ☐ Take 30mg by mouth once daily	**Maintenance:** ☐ 30 tablets ☐ 90 tablets Refills: ________
☐ Skyrizi (risankizumab-rzaa)	**Starter:** ☐ 600mg/10mL vial	**Starter:** ☐ Infuse 600mg intravenously at weeks 0,4,and 8, then start maintenance at week 12.	**Starter:** Qty: ☐ 1 vial ☐ _____vial(s) Refills: ________
	Maintenance: ☐ 360mg/2.4mL solution cartridge ☐ 180mg/1.2ml solution cartridge	**Maintenance:** ☐ Inject_______mg subcutaneously at week 12 and every 8 weeks thereafter ☐ Inject_______mg subcutaneously every 8 weeks	**Maintenance:** Qty: ☐ 1 cartridge Refills: ________
☐ Xeljanz (tofacitinib citrate)	☐ 10mg tablet ☐ 5mg tablet	☐ Take 10mg by mouth twice daily ☐ Take 5mg by mouth twice daily	Qty: ________ Refills: ________
☐ Xeljanz XR (tofacitinib citrate extended release)	☐ 22mg XR tablet ☐ 11mg XR tablet	☐ Take 22mg by mouth once daily ☐ Take 11mg by mouth once daily	Qty: ________ Refills: ________
☐ Zeposia (ozanimod HCl)	**Starter:** ☐ 4 x 0.23mg capsules and 3x 0.46mg capsules **(7 day starter kit)** ☐ 4 x 0.23mg capsules, 3x 0.46mg capsules and 30x 0.92mg capsules **(37 day starter kit)**	**Starter:** Take 0.23mg by mouth once daily on days 1 through 4, take 0.46mg on days 5 through 7, and then take 0.92mg once daily starting on day 8	**Starter:** Qty: ☐ 1 starter kit (7 days) ☐ 1 starter kit (37 days) Refills: 0
	Maintenance: ☐ 0.92mg capsules	**Maintenance:** ☐ Take 0.92mg by mouth once daily	Qty: _____ capsules Refills: ________

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Prescriber Name ____________________

Phone ____________________ Fax ____________________

Email Address ____________________

Office Address ____________________

City ____________________ State __________ ZIP ____________________

State License ____________________ DEA ____________________ NPI ____________________

In order for brand name to be dispensed, prescriber must hand write "Brand Medically Necessary" or "Brand Necessary" in the space below:

____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Prescriber signature required. NO STAMPS. Prescriber attests this is his/her legal signature.

Prescriber signature ____________________ Date ____________________