giant eagle specialty pharmacy

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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

Patient 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:

☐ Other biologics _____ Date _____

☐ Methotrexate Date _____

☐ Oral medications _____ Date _____

☐ Topical medications _____ Date _____

☐ PUVA

☐ UVB

☐ Other _____ Date _____

Additional justification for drug _____

Does the patient have a latex allergy? ☐ Yes ☐ No

☐ NKDA ☐ Known drug allergies _____

Is the patient on concurrent methotrexate? ☐ Yes ☐ No

Concurrent Medications _____

_____

_____

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Cibinqo (abrocitinin)	☐ 50mg tablet ☐ 100mg tablet ☐ 200mg tablet	☐ Take 50mg by mouth once daily ☐ Take 100mg by mouth once daily ☐ Take 200mg by mouth once daily	Qty: ☐ 30 tablets ☐ 90 tablets Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Cimzia (certolizumab pegol)	☐ 200mg/mL prefilled syringe starter kit (1 kit = 6 syringes; 3 doses)	**Starter:** Inject 400mg subcutaneously at weeks 0, 2, and 4	Qty: 1 kit Refills: 0
	☐ 200mg/mL prefilled syringe	**Maintenance:** ☐ Inject 200mg subcutaneously every other week ☐ Inject 400mg subcutaneously every other week ☐ Inject 400mg subcutaneously every 4 weeks	Qty: ☐ 2 prefilled syringes ☐ 4 prefilled syringes ☐ 6 prefilled syringes Refills: _____
☐ Cosentyx (secukinumab) ***ADULT***	☐ 150mg/mL prefilled syringe ☐ 150mg/mL Sensoready auto-injector ☐ 300mg/2mL UnoReady Pen	**Starter:** ☐ Inject 150mg subcutaneously once weekly at week 0, 1, 2, 3, and 4, then 150mg every 4 weeks ☐ Inject 300mg subcutaneously once weekly at week 0, 1, 2, 3, and 4, then 300mg every 4 weeks	Qty: ☐ 5 devices ☐ 10 devices Refills: 0
		Maintenance: ☐ Inject 150mg subcutaneously once every 4 weeks ☐ Inject 300mg subcutaneously once every 4 weeks	Qty: ☐ 1 device ☐ 2 devices ☐ 3 devices ☐ 6 devices Refills: _____
☐ Cosentyx (secukinumab) ***PEDIATRIC*** Patient weight_____kg	☐ 75mg/0.5mL prefilled syringe ☐ 150mg/mL Sensoready auto-injector ☐ 150mg/mL prefilled syringe	**Starter:** ☐ Inject 75mg subcutaneously once weekly at week 0, 1, 2, 3, and 4, then 75mg once every 4 weeks ☐ Inject 150mg subcutaneously once weekly at week 0, 1, 2, 3, and 4, then 150mg once every 4 weeks	Qty: 5 devices Refills: 0
		Maintenance: ☐ Inject 75mg subcutaneously once every 4 weeks ☐ Inject 150mg subcutaneously once every 4 weeks ☐ Inject 300mg subcutaneously once every 4 weeks	Qty: ☐ 1 device ☐ 2 devices ☐ 3 devices ☐ 6 devices Refills: _____
☐ Dupixent (dupilumab) ***ADULT***	☐ 300mg/2mL prefilled syringe ☐ 300mg/2mL pen-injector	**Starter:** ☐ Inject 600mg subcutaneously once	Qty: 2 devices Refills: 0
		Maintenance: ☐ Inject 300mg subcutaneously every other week	Qty: ☐ 2 device ☐ 6 devices Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Dupixent (dupilumab) ***PEDIATRIC*** Patient weight _____kg	☐ 200mg/1.14mL prefilled syringe ☐ 200mg/1.14mL pen-injector **(≥12 years)** ☐ 300mg/2mL prefilled syringe ☐ 300mg/2mL pen-injector **(≥12 years)**	**Starter:** ☐ Inject 400mg subcutaneously once ☐ Inject 600mg subcutaneously once	Qty: 2 devices Refills: 0
		Maintenance: ☐ Inject 200mg subcutaneously every other week ☐ Inject 300mg subcutaneously every other week ☐ Inject 200mg subcutaneously every 4 weeks ☐ Inject 300mg subcutaneously every 4 weeks	☐ Qty: ☐ 2 devices ☐ 4 devices Other (must be multiples of 2): _____ Refills: _____
☐ Enbrel (etanercept)	☐ 25mg/0.5mL vial ☐ 25mg/0.5mL prefilled syringe ☐ 50mg/mL prefilled syringe ☐ 50mg/mL Sureclick auto-injector ☐ 50mg/mL Mini Cartridge	**Starter:** ☐ Inject 50mg subcutaneously twice weekly for 3 months	Qty: ☐ 8 devices ☐ 24 devices Refills: _____
		Maintenance: ☐ Inject 50mg subcutaneously once weekly ☐ Other: _____	Qty: ☐ 4 devices ☐ 12 devices Other: _____ Refills: _____
☐ Ilumya (tildrakizumab-asmn)	100mg/mL prefilled syringe	**Starter:** ☐ Inject 100mg subcutaneously at weeks 0, 4, and every 12 weeks thereafter	Qty: 2 syringes Refills: 0
		Maintenance: ☐ Inject 100mg subcutaneously every 12 weeks	Qty: 1 syringe Refills: _____
☐ Humira (adalimumab)	**Starter:** ☐ **CITRATE FREE** **Psoriasis/Uveitis or adolescent HS Starter Kit** (1 x 80mg/0.8mL and 2x 40mg/0.4mL) pen-injector ☐ **HS Starter Kit** (3x 80mg/0.8mL) pen-injector	☐ **Psoriasis/Uveitis/adolescent HS Starter:** Inject 80mg subcutaneously on day 1 as a single dose, then inject 40mg subcutaneously every other week beginning 1 week after the initial dose on day 8 ☐ **HS Starter:** Inject 160mg subcutaneously on day 1 followed by 80mg subcutaneously 2 weeks later on day 15	Qty: 1 kit Refills: 0
	Maintenance: **CITRATE FREE** ☐ 40mg/0.4mL pen-injector ☐ 40mg/0.4mL prefilled syringe ☐ 80mg/0.8mL pen-injector **ORIGINAL FORMULATION** ☐ 40mg/0.8mL pen-injector ☐ 40mg/0.8mL prefilled syringe	**Maintenance:** ☐ Inject 40mg subcutaneously every other week ☐ Inject 40mg subcutaneously every week ☐ Inject 80mg subcutaneously every other week	Qty: ☐ 2 devices ☐ 4 devices ☐ 6 devices ☐ Other (must be in multiples of 2): Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Olumiant (baricitinib)	☐ 2mg tablet ☐ 4mg tablet	☐ Take 2mg by mouth once daily ☐ Take 4mg by mouth once daily	Qty: ☐ 30 tablets ☐ 90 tablets Refills:_____
☐ Opzelura (ruxolitinib)	60 gram tube	Apply a thin layer topically to affected area twice daily	Qty: ☐ 1 tube ☐ 2 tubes ☐ 3 tubes Refills:_____
☐ Orencia (abatacept)	☐ 125mg/mL ClickJect auto-injector ☐ 125mg/mL prefilled syringe	Inject 125mg subcutaneously once weekly	Qty: ☐ 4 devices ☐ 12 devices Refills:_____
☐ Otezla (apremilast) CrCL:_____	☐ 55 tablet Starter pack (consisting of 10mg-20mg-30mg tablets for 28 days)	**Starter:** Take by mouth as directed per package	Qty: 1 starter pack Refills: 0
	☐ 30mg tablet	**Maintenance:** ☐ Take 1 tablet by mouth twice daily ☐ Other:_____	Qty: ☐ 60 tablets ☐ 180 tablets ☐ Other:_____ Refills:_____
☐ Remicade (infliximab) OR biosimilar ☐ Avsola (infliximab-axxq) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda)	100mg vial	**Starter:** Infuse _____mg (5mg/kg) intravenously at week 0, 2, and 6, then every 8 weeks thereafter Patient weight:_____kg **Maintenance:** Infuse _____mg (5mg/kg) intravenously every 8 weeks Patient weight:_____kg	Qty: _____ vial(s) Refills:_____
☐ Rinvoq (upadacitinib)	☐ 15mg tablet ☐ 30mg tablet	☐ Take 15mg by mouth once daily ☐ Take 30mg by mouth once daily	Qty: ☐ 30 tablets ☐ 90 tablets Refills:_____
☐ Siliq (brodalumab)	210mg/1.5mL prefilled syringes (2 pack)	**Starter:** ☐ Inject 210mg subcutaneously at weeks 0,1, and 2 followed by 210mg every 2 weeks	Qty: 4 syringes Refills: 0
		Maintenance: ☐ Inject 210mg subcutaneously every 2 weeks	Qty: ☐ 2 syringes ☐ 6 syringes Refills:_____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Simponi (golimumab)	☐ 50mg/0.5mL Smartject auto-injector ☐ 50mg/0.5mL prefilled syringe	Inject 50mg subcutaneously once per month	Qty: ☐ 1 device ☐ 3 devices Refills:_____
☐ Simponi Aria (golimumab) ***ADULT*** Patient weight:_____kg	50mg/4mL vial	**Starter:** ☐ Administer _____ mg (2mg/kg) intravenously at weeks 0, 4, then every 8 weeks thereafter	Qty: _____vial(s) Refills: 0
		Maintenance: ☐ Administer _____ mg (2mg/kg) intravenously every 8 weeks	Qty: _____vial(s) Refills:_____
☐ Simponi Aria (golimumab) ***PEDIATRIC*** Patient weight:_____kg	50mg/4mL vial	**Starter:** ☐ Administer _____ mg (80mg/m2) intravenously at weeks 0, 4, then every 8 weeks thereafter	Qty: _____vial(s) Refills: 0
		Maintenance: ☐ Administer _____ mg (80mg/m2) intravenously every 8 weeks	Qty: _____vial(s) Refills:_____
☐ Sotyktu (deucravacitinib)	6 mg tablet	Take 6mg by mouth once daily	Qty: ☐ 30 tablets ☐ 90 tablets Refills:_____
☐ Skyrizi (risankizumab-rzaa)	☐ 150mg/mL prefilled syringe ☐ 150mg/mL auto-injector	**Starter:** ☐ Inject 150mg subcutaneously at weeks 0,4, and then every 12 weeks thereafter	Qty: 2 devices Refills: 0
		Maintenance: ☐ Inject 150mg subcutaneously every 12 weeks	Qty: 1 device Refills:_____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Stelara (ustekinumab) _____ Patient weight: kg	☐ 45mg/0.5mL prefilled syringe ☐ 90mg/mL prefilled syringe	**Starter:** ☐ Inject 45mg subcutaneously at weeks 0,4, and then every 12 weeks thereafter ☐ Inject 90mg subcutaneously at weeks 0,4, and then every 12 weeks thereafter	Qty: 2 prefilled syringes Refills: 0
		Maintenance: ☐ Inject 45mg subcutaneously every 12 weeks ☐ Inject 90mg subcutaneously every 12 weeks	Qty: 1 prefilled syringe Refills: _____
☐ Taltz (ixekizumab)	☐ 80mg/mL autoinjector ☐ 80mg/mL prefilled syringe	**Plaque psoriasis (Ps) Starter:** ☐ Inject 160mg (2 injections) subcutaneously once at week 0, followed by 80mg at weeks 2,4,6,8,10,and 12, then 80mg every 4 weeks **Psoriatic arthritis (PsA) Starter:** ☐ Inject 160mg (2 injections) subcutaneously once at week 0, followed by 80mg every 4 weeks	☐ 8 devices (Ps) ☐ 2 devices (PsA) Refills 0
		Maintenance: ☐ Inject 80mg subcutaneously every 4 weeks ☐ Inject 80mg subcutaneously every 2 weeks	Qty: ☐ 1 device ☐ 2 devices ☐ 3 devices ☐ 6 devices Refills: _____
☐ Tremfya (guselkumab)	☐ 100mg/mL auto-injector ☐ 100mg/mL prefilled syringe	**Starter:** ☐ Inject 100mg subcutaneously at weeks 0,4, and every 8 weeks thereafter	Qty: 2 devices Refills: 0
		Maintenance: ☐ Inject 100mg subcutaneously every 8 weeks	Qty: 1 device Refills: _____
☐ Other: _____			Qty: _____ 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 _____