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

Type: ☐ clinically isolated syndrome ☐ relapsing-remitting ☐ primary progressive

☐ secondary progressive without relapses ☐ secondary progressive with relapses ☐ progressive relapsing

Height: _____ cm Weight: _____ kg Date Recorded: _____

TB Test Results _____ Date _____

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

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

☐ New therapy induction ☐ Therapy change

Previous therapies tried and failed: _____

Reason for discontinuation: _____

☐ NKDA ☐ Known drug allergies _____

Concurrent Medications _____

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Dalfampridine ER	10mg ER tablet	Take 10mg by mouth twice daily	Qty: ☐ 60 tablets ☐ 180 tablets Refills: _____
☐ Avonex (interferon beta-1a)	☐ Avonex 30mcg auto-injector ☐ Avonex 30mcg prefilled syringe	Inject 30mcg intramuscularly once weekly	Qty: ☐ 4 devices ☐ 12 devices Refills: _____
☐ Betaseron (interferon beta-1b)	0.3mg vial	☐ Sig Titration Per Package Insert: **Weeks 1-2**: inject 0.0625mg subcutaneously every other day **Weeks 3-4**: inject 0.125mg subcutaneously every other day **Weeks 5-6**: inject 0.1875mg subcutaneously every other day **Week 7 and thereafter**: inject 0.25mg subcutaneously every other day ☐ Inject 0.25mg subcutaneously every other day	Qty: ☐ 1 kit (14 single dose vials) ☐ 3 kits (42 single dose vials) Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Copaxone (glatiramer acetate)	☐ 20mg/mL prefilled syringe	Inject 20mg subcutaneously daily	Qty: ☐ 30 syringes ☐ 90 syringes Refills: _____
	☐ 40mg/mL prefilled syringe	Inject 40mg subcutaneously 3 times a week	Qty: ☐ 12 syringes ☐ 36 syringes Refills: _____
☐ Extavia (interferon beta-1b)	0.3mg vial	☐ Sig Titration Per Package Insert: **Weeks 1-2** inject 0.0625mg subcutaneously every other day **Weeks 3-4**: inject 0.125mg subcutaneously every other day **Weeks 5-6**: inject 0.1875mg subcutaneously every other day **Week 7 and thereafter**: inject 0.25mg subcutaneously every other day ☐ Inject 0.25mg subcutaneously every other day	Qty: ☐ 1 kit (15 single dose vials) ☐ 3 kits (45 single dose vials) Refills: _____
☐ Gilenya (fingolimod)	0.5mg capsule	Take 1 capsule by mouth daily	Qty: ☐ 30 capsules ☐ 90 capsules Refills: _____
☐ Glatopa (glatiramer acetate)	☐ 20mg/mL prefilled syringe	Inject 20mg subcutaneously daily	Qty: ☐ 30 syringes ☐ 90 syringes Refills: _____
	☐ 40mg/mL prefilled syringe	Inject 40mg subcutaneously 3 times a week	Qty: ☐ 12 syringes ☐ 36 syringes Refills: _____
☐ Kesimpta (ofatumumab)	20mg/0.4mL auto-injector	**Starter:** ☐ Inject 20mg subcutaneously once weekly for 3 doses at weeks 0, 1, and 2. Then start maintenance dose at week 4.	Qty: 3 auto-injectors Refills: 0
		Maintenance: ☐ Inject 20mg subcutaneously once monthly	Qty: ☐ 1 auto-injector ☐ 3 auto-injectors Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Plegridy (peginterferon beta-1a)	**Starter:** ☐ 63mcg/0.5mL and 94mcg/0.5mL auto-injector kit ☐ 63mcg/0.5mL and 94mcg/0.5mL prefilled syringe kit	**Starter:** Inject 63mcg subcutaneously on Day 1, inject 94mcg on day 15, then inject 125mcg on day 29 and every 14 days thereafter	Qty: 1 kit Refills: 0
	Maintenance: ☐ 125mcg/0.5mL auto-injector ☐ 125mcg/0.5mL subcutaneous prefilled syringe ☐ 125mcg/0.5mL intramuscular prefilled syringe	**Maintenance:** ☐ Inject 125mcg subcutaneously every 14 days ☐ Inject 125mcg intramuscularly every 14 days	Qty: ☐ 2 devices ☐ 6 devices Refills: _____
☐ Rebif (interferon beta-1a)	**Starter:** ☐ 6 x 8.8mcg and 6 x 22mcg prefilled syringes **starter kit** ☐ 6 x 8.8mcg and 6 x 22mcg Rebidose auto-injector **starter kit (44mcg dose only)**	**Starter:** ☐ Sig Titration for 22mcg dose **(prefilled syringe only)**: **Weeks 1-2:** inject 4.4mcg subcutaneously 3 times per week **Weeks 3-4:** inject 11mcg subcutaneously 3 times per week **Weeks 5 and thereafter:** inject 22mcg subcutaneously 3 times per week ☐ Sig Titration for 44mcg dose: **Weeks 1-2:** inject 8.8mcg subcutaneously 3 times per week **Weeks 3-4:** inject 22mcg subcutaneously 3 times per week **Weeks 5 and thereafter:** inject 44mcg subcutaneously 3 times per week	Qty: 1 starter kit Refills: 0
	Maintenance: ☐ 22mcg Rebidose auto-injector ☐ 44mcg Rebidose auto-injector ☐ 22mcg prefilled syringe ☐ 44mcg prefilled syringe	☐ Inject 22mcg subcutaneously 3 times per week ☐ Inject 44mcg subcutaneously 3 times per week	Qty: ☐ 12 devices ☐ 36 devices Refills: _____
☐ Dimethyl Fumarate	**Starter:** ☐ 120mg capsule	**Starter:** Take 120mg by mouth twice a day for 7 days	Qty: 14 capsules Refills: 0
	Maintenance: ☐ 240mg capsule	**Maintenance:** Take 240mg by mouth twice a day	Qty: ☐ 60 capsules ☐ 180 capsules Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Mayzent (siponimod)	☐ 1mg Starter Pak ☐ 2mg Starter Pak ☐ 1mg tablet ☐ 2mg tablet	☐ Take 0.25mg by mouth once daily on days 1 and 2, then 0.5mg once daily on day 3, then 0.75mg once daily on day 4 ☐ Take 0.25mg by mouth once daily on days 1 and 2, then 0.5mg once daily on day 3, then 0.75mg once daily on day 4, then 1.25mg once daily on day 5 ☐ Take 1 tablet by mouth daily	Qty: ☐ 7 tablets ☐ 12 tablets ☐ 30 tablets ☐ 90 tablets Refills: _____
☐ Zeposia (ozanimod HCl)	**Starter:** ☐ 4x 0.23mg capsules and 3x 0.46mg capsules **(7 day starter kit)** ☐ 4x 0.23mg capsules, 3x 0.46mg capsules and 30x 0.92mg capsules **(37 day starter kit)**	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	Qty: ☐ 1 starter kit (7 days) ☐ 1 starter kit (37 days) Refills: 0
	Maintenance: ☐ 0.92mg capsule	Take 0.92mg by mouth once daily	Qty: ☐ 30 capsules ☐ 90 capsules Refills: _____
☐ Other: _____			Qty: _____ Refills: _____

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 _____