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

If yes, please indicate start date _____ 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: _____

☐ Hydroxychloroquine Date: _____

☐ Leflunomide Date: _____

☐ Azathioprine Date: _____

☐ Sulfasalazine Date: _____

☐ Other biologics _____ Date: _____

☐ Other _____ Date _____

Additional justification for drug _____

_____

☐ NKDA ☐ Known drug allergies _____

Concurrent Medications _____

_____

_____

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Actemra (tocilizumab) ***ADULT*** Patient weight _____kg	☐ 162mg/0.9mL prefilled syringe ☐ 162mg/0.9mL ACTpen	☐ Inject 162mg subcutaneously every other week ☐ Inject 162mg subcutaneously every week	Qty: ☐ 2 devices ☐ 4 devices ☐ 6 devices ☐ 12 devices Refills: _____
☐ Actemra (tocilizumab) ***PEDIATRIC*** Patient weight _____kg	☐ 162mg/0.9mL prefilled syringe ☐ 162mg/0.9mL ACTpen	☐ Inject 162mg subcutaneously every three weeks ☐ Inject 162mg subcutaneously every two weeks	Qty: _____devices Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Cimzia (certolizumab pegol)	**Starter:** ☐ 200mg/mL prefilled syringes (1 kit = 6 syringes, 3 doses)	**Starter:** Inject 400mg subcutaneously at weeks 0, 2, and 4	Qty: 1 kit Refills: 0
	Maintenance: ☐ 200mg/mL prefilled syringes (total dose = 400mg)	**Maintenance:** ☐ Inject the contents of 2 syringes (400mg) subcutaneously every 4 weeks ☐ Inject the contents of 1 syringe (200mg) subcutaneously every 2 weeks	Qty: ☐ 2 syringes ☐ 6 syringes Refills: _____
☐ Cosentyx (secukinumab) ***ADULT***	☐ 150mg/mL prefilled syringe ☐ 150mg/mL Sensoready auto-injector	**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 ☐ Inject 150mg subcutaneously once weekly at week 0, 1, 2, 3, and 4	Qty: 5 devices Refills: 0
		Maintenance: ☐ Inject 75mg subcutaneously once every 4 weeks ☐ Inject 150mg subcutaneously once every 4 weeks	Qty: ☐ 1 device ☐ 3 devices 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	☐ Inject 50mg subcutaneously once weekly ☐ Other: _____ _____ _____	Qty: ☐ 4 devices ☐ 12 devices ☐ Other: Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Humira (adalimumab) ***ADULT***	**Starter:** **CITRATE FREE** ☐ **Psoriasis/Uveitis or adolescent HS Starter Kit** (1x 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 as a single dose, then inject 40mg subcutaneously every other week beginning 1 week after the initial dose **HS Starter:** ☐ Inject 160mg subcutaneously followed by 80mg subcutaneously 2 weeks later on Day 15	Qty: 1 starter 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 ☐ 6 devices ☐ Other (must be in multiples of 2) Refills: _____
☐ Humira (adalimumab) ***PEDIATRIC*** Patient weight _____kg	**CITRATE FREE** ☐ 10mg/0.1mL prefilled syringe ☐ 20mg/0.2mL prefilled syringe ☐ 40mg/0.4mL pen-injector ☐ 40mg/0.4mL prefilled syringe	☐ Inject 10mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week	Qty: ☐ 2 devices ☐ 6 devices ☐ Other (must be in multiples of 2) Refills: _____
☐ Kevzara (sarilumab)	☐ 200mg/1.14mL prefilled pen ☐ 200mg/1.14mL prefilled syringe ☐ 150mg/1.14mL prefilled pen ☐ 150mg/1.14mL prefilled syringe	☐ Inject 200mg subcutaneously once every 2 weeks ☐ Inject 150mg subcutaneously once every 2 weeks	Qty: ☐ 2 devices ☐ 6 devices 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 _____