giant eagle specialty pharmacy

SpecialtyRx.GiantEagle.com
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 _____

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 _____

Street Address _____

Street Address Line 2 _____

City _____ State _____ ZIP _____

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

☐ NKDA ☐ Known drug allergies _____

Concurrent Medications _____

Date of last injection (if applicable) _____ **DATE OF NEXT INJECTION** _____

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Sublocade 300mg (buprenorphine ER in ATRIGEL delivery system)	300mg/1.5mL prefilled syringe	Administer 1 injection subcutaneously into the abdomen once monthly. **MUST BE ADMINISTERED BY A HEALTHCARE PROVIDER. DO NOT DISPENSE DIRECTLY TO PATIENT.**	Qty: 1 prefilled syringe Refills: 0 or specify below _____

• Sublocade® prescriptions are shipped only to the prescriber's healthcare setting address as listed on their DEA registration and is never dispensed directly to patients.

• All prescriptions for Sublocade® should be sent directly to the REMS-authorized dispensing pharmacy. For patient support and program information, please visit the manufacturer's product support website www.Sublocade.com

This form is provided for informational and convenience purposes only. The completion of this form by a prescriber may not constitute a valid prescription in accordance with state law. The pharmacy may contact the prescriber upon receipt of this enrollment form in order to obtain a valid prescription under state law.

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Prescriber Name _____

State License _____ DEA _____ NPI _____

Phone _____ Fax _____ Email Address _____

Facility Name _____ Facility DEA#_____

Office/Shipping Address (must match DEA registered address)

_____

City _____ State _____ ZIP _____

I hereby authorize Giant Eagle to contact my prescribing provider to coordinate the delivery, receipt, and storage of my prescription medication for the sole purpose of administration by my provider at my next scheduled appointment. Signature serves as Patient Ship Authorization.

Patient authorization signature _____

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 _____