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

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 _____

☐ Sulfazalazine/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	**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 _____