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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
☐ 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: ______

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/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, 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: ____________
☐ 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: ____________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/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:__________
☐ Olumiant (baricitinib)	☐ 2mg tablet ☐ 4mg tablet	☐ Take 2mg by mouth once daily ☐ Take 4mg by mouth once daily	Qty: ☐ 30 tablets ☐ 90 tablets Refills:__________
☐ Orencia (abatacept)	☐ 125mg/mL ClickJect auto-injector ☐ 125mg/mL prefilled syringe	Inject 125mg subcutaneously once weekly	Qty: ☐ 4 devices ☐ 12 devices Refills:__________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/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	Qty: ______ vial(s) Refills: __________
		Maintenance: Infuse ________mg (5mg/kg) intravenously every 8 weeks Patient weight: __________kg	
☐ 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: __________
☐ 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: __________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/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: ______________
☐ 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:______________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/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:______________

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 ____________________