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 ______________________________________

☐ 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: ______________

☐ NKDA ☐ Known drug allergies ______________________

Concurrent Medications ______________________

____

____

Prescribing Information

Medication/ Indication	Strength	Directions	Qty/Refills
☐ Dupixent (dupilumab) ***ADULT*** ☐ Asthma ☐ Atopic Dermatitis ☐ Prurigo Nodularis	☐ 300mg/2mL prefilled syringe ☐ 300mg/2mL pen-injector ☐ 200mg/1.14mL prefilled syringe ☐ 200mg/1.14mL pen-injector	**Starter:** ☐ Inject 600mg subcutaneously once ☐ Inject 400mg subcutaneously once	**Starter:** Qty: 2 devices Refills: 0
		Maintenance: ☐ Inject 300mg subcutaneously every other week ☐ Inject 200mg subcutaneously every other week	**Maintenance:** Qty: ☐ 2 devices ☐ 6 devices Refills: ________
☐ Eosinophilic Esophagitis	☐ 300mg/2mL prefilled syringe ☐ 300mg/2mL pen-injector	Inject 300mg subcutaneously once weekly	Qty: ☐ 4 devices ☐ 12 devices Refills: ________
☐ Rhinosinusitis with nasal polyposis	☐ 300mg/2mL prefilled syringe ☐ 300mg/2mL pen-injector	Inject 300mg subcutaneously once every other week	Qty: ☐ 2 devices ☐ 6 devices Refills: ________
☐ Dupixent (dupilumab) ***PEDIATRIC*** ☐ Asthma Patient weight ______ kg ☐ Atopic Dermatitis Patient weight ______ kg ☐ Eosinophilic esophagitis Patient weight ______ kg	**Starter:** ☐ 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	**Starter:** Qty: 2 devices Refills: 0
	Maintenance: ☐ 100mg/0.67mL prefilled syringe ☐ 200mg/1.14mL prefilled syringe ☐ 200mg/1.14mL pen-injector **(≥12 years)** ☐ 300mg/2mL prefilled syringe ☐ 300mg/2mL pen-injector **(≥12 years)**	**Maintenance:** ☐ Inject 100mg subcutaneously once every other week ☐ Inject 200mg subcutaneously once every other week ☐ Inject 300mg subcutaneously once every other week ☐ Inject 200mg subcutaneously every 4 weeks ☐ Inject 300mg subcutaneously every 4 weeks ☐ Inject 300mg subcutaneously once weekly	**Maintenance:** Qty: ☐ 2 devices ☐ 4 devices ☐ 12 devices ☐ Other (must be in multiples of 2): ________ 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 ________________