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 _____

☐ 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 therapy before? ☐ Yes ☐ No

If yes, was patient: ☐ Non-responder ☐ Responder ☐ Reinfected

Previous Treatment: _____

Previous Treatment Start Date: _____ Previous Treatment End Date: _____

HCV RNA _____ Date Recorded: _____

Viral Load: _____ Date Recorded: _____

Genotype: ☐ 1A ☐ 1B ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

☐ Cirrhotic If Cirrhotic: ☐ Compensated ☐ Decompensated ☐ Non-Cirrhotic

Post-liver Transplant ☐ No ☐ Yes Transplant Date (if applicable): _____

HIV Status: ☐ Negative ☐ Positive Date: _____

Hep B Status: ☐ Negative ☐ Positive Date: _____

☐ NKDA ☐ Known drug allergies _____

Concurrent Medications _____

_____

_____

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Epclusa (sofosbuvir/velpatasvir) ***ADULT***	sofosbuvir 400mg/velpatasvir 100mg tablet	Take 1 tablet by mouth once daily	Qty: ☐ 28 tablets ☐ 84 tablets Refills: _____
☐ Epclusa (sofosbuvir/velpatasvir) ***PEDIATRIC*** Patient Weight _____ kg	☐ sofosbuvir 200mg/velpatasvir 50mg tablet ☐ sofosbuvir 150mg/velpatasvir 37.5mg packet ☐ sofosbuvir 200mg/velpatasvir 50mg packet	_____ _____ _____ _____ _____	Qty: ☐ 28 tablets ☐ 28 packets ☐ 84 tablets ☐ 84 packets Refills: _____
☐ Harvoni (ledipasvir/sofosbuvir) ***ADULT***	ledipasvir 90mg/sofosbuvir 400mg tablet	Take 1 tablet by mouth once daily	Qty: ☐ 28 tablets ☐ 84 tablets Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Harvoni (ledipasvir/sofosbuvir) ***PEDIATRIC*** Patient Weight _____ kg	☐ ledipasvir 45mg/sofosbuvir 200mg tablet ☐ ledipasvir 33.75mg/ sofosbuvir 150mg pellet pack ☐ ledipasvir 45mg/sofosbuvir 200mg pellet pack	_____ _____ _____ _____ _____	Qty: ☐ 28 tablets ☐ 28 packets ☐ 84 tablets ☐ 84 packets Refills: _____
☐ Mavyret (glecaprevir/pibrentasvir) ***ADULT***	glecaprevir 100mg/ pibrentasvir 40mg	Take 3 tablets by mouth once daily with food	Qty: ☐ 84 tablets ☐ Other: _____ Refills: _____
☐ Mavyret (glecaprevir/pibrentasvir) ***PEDIATRIC*** Patient Weight _____ kg	glecaprevir 50mg/ pibrentasvir 20mg oral pellet packet	Mix _____ packet(s) of oral pellets with a small amount of soft food and swallow once daily	Qty: ☐ 28 packets ☐ Other: _____ Refills: _____
☐ Ribavirin	☐ Ribavirin 200mg tablet ☐ Ribavirin 200mg capsule	Take _____ tablets/capsules by mouth every morning and _____ tablets/capsules every evening with food	Qty: _____ Refills: _____
☐ Sovaldi (sofosbuvir)	☐ sofosbuvir 400mg tablet ☐ sofosbuvir 200mg tablet	Take 1 tablet by mouth once daily	Qty: ☐ 28 tablets ☐ 84 tablets Refills: _____
☐ Vosevi (sofosbuvir/velpatasvir/ voxilaprevir)	sofosbuvir 400mg/velpatasvir 100mg/voxilaprevir 100mg tablet	Take 1 tablet by mouth once daily with food	Qty: ☐ 28 tablets ☐ 84 tablets Refills: _____
☐ Zepatier (elbasvir/grazoprevir)	elbasvir 50mg/grazoprevir 100mg tablet	Take 1 tablet by mouth once daily	Qty: ☐ 28 tablets ☐ 84 tablets 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 _____