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 this therapy before? ☐ Yes ☐ No

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

If patient is new to injectable therapy, did the patient have an oral trial of the medication?

☐ Yes ☐ No If yes: Medication _____ Date _____ Length of oral therapy _____

☐ NKDA ☐ Known drug allergies _____

Concurrent Medications _____

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Abilify Maintena (aripiprazole)	☐ 300mg dual chamber syringe ☐ 300mg powdered vial ☐ 400mg dual chamber syringe ☐ 400mg powdered vial	☐ Inject 300mg intramuscularly once monthly ☐ Inject 400mg intramuscularly once monthly	Qty: 1 kit Refills:_____
☐ Aristada (aripiprazole lauroxil)	☐ 441mg/1.6mL prefilled syringe ☐ 662mg/2.4mL prefilled syringe ☐ 882mg/3.2mL prefilled syringe ☐ 1064mg/3.9mL prefilled syringe	☐ Inject 441mg intramuscularly once monthly ☐ Inject 662mg intramuscularly once monthly ☐ Inject 882mg intramuscularly once monthly ☐ Inject 882mg intramuscularly every 6 weeks ☐ Inject 1064mg intramuscularly every 2 months	Qty: 1 prefilled syringe Refills:_____
☐ Aristada Initio (aripiprazole lauroxil)	675mg/2.4mL prefilled syringe	Inject 675mg intramuscularly once	Qty: 1 prefilled syringe Refills: 0
☐ Invega Hafyera (paliperidone palmitate)	☐ 1092mg/3.5mL prefilled syringe ☐ 1560mg/5mL prefilled syringe	Inject the contents of 1 syringe intramuscularly every 6 months	Qty: 1 prefilled syringe Refills:_____
☐ Invega Sustenna (paliperidone palmitate)	**Starter:** ☐ 234mg/1.5mL prefilled syringe	**Starter:** Inject 234mg intramuscularly on day 1 into the deltoid muscle	**Starter:** Qty: 1 prefilled syringe Refills: 0
	Dose 2: ☐ 156mg/mL prefilled syringe	**Dose 2:** Inject 156mg intramuscularly into the deltoid muscle 1 week after 234mg injection	**Dose 2:** Qty: 1 prefilled syringe Refills: 0
	Maintenance: ☐ 39mg/0.25mL prefilled syringe ☐ 78mg/0.5mL prefilled syringe ☐ 117mg/0.75mL prefilled syringe ☐ 156mg/mL prefilled syringe ☐ 234mg/1.5mL prefilled syringe	**Maintenance:** Inject the contents of 1 syringe intramuscularly every month	**Maintenance:** Qty: 1 prefilled syringe Refills:_____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Invega Trinza (paliperidone palmitate)	☐ 273mg/0.875mL prefilled syringe ☐ 410mg/1.315mL prefilled syringe ☐ 546mg/1.75mL prefilled syringe ☐ 819mg/2.625mL prefilled syringe	Inject the contents of 1 syringe intramuscularly every 3 months	Qty: 1 prefilled syringe Refills: _____
☐ Perseris (risperidone)	☐ 90mg prefilled syringe ☐ 120mg prefilled syringe	☐ Inject 90mg subcutaneously once monthly ☐ Inject 120mg subcutaneously once monthly	Qty: 1 prefilled syringe Refills: _____
☐ Risperdal Consta (risperidone)	☐ 12.5mg vial kit ☐ 25mg vial kit ☐ 37.5mg vial kit ☐ 50mg vial kit	☐ Inject 25mg intramuscularly every 2 weeks ☐ Inject 37.5mg intramuscularly every 2 weeks ☐ Inject 50mg intramuscularly every 2 weeks Other: _____	Qty: ☐ 1 kit ☐ 2 kits ☐ Other: Refills: _____
☐ Other: _____			Qty: _____ Refills: _____

Prescriber Name _____

Phone _____ Fax _____

Email Address _____

Office Address _____

City _____ State _____ ZIP _____

State License _____ DEA _____ NPI _____

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 _____

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 _____