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 ____________ Secondary diagnosis ____________

Has the patient been on this therapy before? ☐ Yes ☐ No

Date of Last injection __________ Date of first/next injection __________

Patient Height __________cm Weight __________kg BSA __________Date recorded: __________

Laboratory results:

WBC __________ cell/mm³ Date __________

ANC __________ cell/mm³ Date __________

Platelets __________ cell/mm³ Date __________

☐ NKDA ☐ Known drug allergies ______________________

Concurrent Medications ______________________

Prescribing Information

Medication	Strength	Directions MUST INCLUDE DAILY, WEEKLY, CYCLIC, ONE-TIME, and DURATION OF THERAPY	Qty/Refills
☐ Fulphila (pegfilgrastim-jmdb)	6mg/0.6mL prefilled syringe	Administer 6mg subcutaneously ______ ______ Cycle length: ______	Qty: ______ Refills: ______
☐ Granix (tbo-filgrastim)	☐ 300mcg/mL vial ☐ 300mcg/0.5mL prefilled syringe ☐ 480mcg/1.6mL vial ☐ 480mcg/0.8mL prefilled syringe	Administer ______ mcg ☐ subcutaneously ☐ intravenously ______ ______ Cycle length: ______	Qty: ______ Refills: ______
☐ Leukine (sargramostim)	250mcg vial	Administer ______ mcg ☐ subcutaneously ☐ intravenously ______ ______ Cycle length: ______	Qty: ______ Refills: ______

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Neupogen (filgrastim)	☐ 300mcg/mL vial ☐ 300mcg/0.5mL SingleJect prefilled syringe ☐ 480mcg/1.6mL vial ☐ 480mcg/0.8mL SingleJect prefilled syringe	Administer ______ mcg ☐ subcutaneously ☐ intravenously ______ ______ Cycle length: ______	Qty: ______ Refills: ______
☐ Neulasta (pegfilgrastim)	6mg/0.6mL prefilled syringe	Administer 6mg subcutaneously ______ ______ Cycle length: ______	Qty: ______ Refills: ______
☐ Neulasta Onpro (pegfilgrastim)	6mg/0.6mL Onpro On-body injector Kit	Administer 6mg subcutaneously every ______ days as directed. To be applied by a healthcare professional. Cycle length: ______	Qty: ______ Refills: ______
☐ Nivestym (filgrastim-aafi)	☐ 300mcg/mL vial ☐ 300mcg/0.5mL prefilled syringe ☐ 480mcg/1.6mL vial ☐ 480mcg/0.8mL prefilled syringe	Administer ______ mcg ☐ subcutaneously ☐ intravenously ______ ______ Cycle length: ______	Qty: ______ Refills: ______
☐ Udenyca (pegfilgrastim-cbqv)	6mg/0.6mL prefilled syringe	Administer 6mg subcutaneously ______ ______ Cycle length: ______	Qty: ______ Refills: ______
☐ Zarxio (filgrastim-sndz)	☐ 300mcg/0.5mL prefilled syringe ☐ 480mcg/0.8mL prefilled syringe	Administer ______ mcg subcutaneously ______ ______ Cycle length: ______	Qty: ______ 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 ______________