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

☐ Right Knee ☐ Left Knee ☐ Bilateral knees ☐ Other site (Please specify): ______________

Height: ________cm Weight: ________ kg Date Recorded: ______________

☐ NKDA ☐ Known drug allergies ______________________

Concurrent Medications ______________________

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Durolane (hyaluronate sodium)	60mg/3mL prefilled syringe	Inject 60mg (3mL) intra-articularly once	Qty: ☐ 1 prefilled syringe ☐ 2 prefilled syringes Refills: ________
☐ Euflexxa (hyaluronate sodium)	20mg/2mL prefilled syringe	Inject 20mg (2mL) intra-articularly once weekly for 3 weeks	Qty: ☐ 3 prefilled syringes ☐ 6 prefilled syringes Refills: ________
☐ Gel-One (hyaluronate sodium cross-linked)	30mg/3mL prefilled syringe	Inject 30mg (3mL) intra-articularly once	Qty: ☐ 1 prefilled syringe ☐ 2 prefilled syringes Refills: ________
☐ Gelsyn-3 (hyaluronate sodium)	16.8mg/2mL prefilled syringe	Inject 16.8mg (2mL) intra-articularly once weekly for 3 weeks	Qty: ☐ 3 prefilled syringes ☐ 6 prefilled syringes Refills: ________
☐ GenVisc 850 (hyaluronate sodium)	25mg/2.5mL prefilled syringe	☐ Inject 25mg (2.5mL) intra-articularly once weekly for 5 weeks ☐ Inject 25mg (2.5mL) intra-articularly once weekly for 3 weeks	Qty: ☐ 5 prefilled syringes ☐ 10 prefilled syringes ☐ 3 prefilled syringes ☐ 6 prefilled syringes Refills: ________
☐ Hyalgan (hyaluronate sodium)	20mg/2mL prefilled syringe	☐ Inject 20mg (2mL) intra-articularly once weekly for 5 weeks ☐ Inject 20mg (2mL) intra-articularly once weekly for 3 weeks	Qty: ☐ 5 prefilled syringes ☐ 10 prefilled syringes ☐ 3 prefilled syringes ☐ 6 prefilled syringes Refills: ________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Hymovis (hyaluronate sodium)	24mg/3mL prefilled syringe	Inject 24mg (3mL) intra-articularly once weekly for 2 weeks	Qty: ☐ 2 prefilled syringes ☐ 4 prefilled syringes Refills:________
☐ Monovisc (hyaluronate sodium)	88mg/4mL prefilled syringe	Inject 88mg (4mL) intra-articularly once	Qty: ☐ 1 prefilled syringe ☐ 2 prefilled syringes Refills:________
☐ Orthovisc (hyaluronate sodium)	30mg/2mL prefilled syringe	☐ Inject 30mg (2mL) intra-articularly once weekly for 3 weeks ☐ Inject 30mg (2mL) intra-articularly once weekly for 4 weeks	Qty: ☐ 3 prefilled syringes ☐ 6 prefilled syringes ☐ 4 prefilled syringes ☐ 8 prefilled syringes Refills:________
☐ Supartz FX (hyaluronate sodium)	25mg/2.5mL prefilled syringe	☐ Inject 25mg (2.5mL) intra-articularly once weekly for 5 weeks ☐ Inject 25mg (2.5mL) intra-articularly once weekly for 3 weeks	Qty: ☐ 5 prefilled syringes ☐ 10 prefilled syringes ☐ 3 prefilled syringes ☐ 6 prefilled syringes Refills:________
☐ Synvisc-One (hyaluronate sodium)	48mg/6mL prefilled syringe	Inject 48mg (6mL) intra-articularly once	Qty: ☐ 1 prefilled syringe ☐ 2 prefilled syringes Refills:________
☐ Triluron (hyaluronate sodium)	20mg/2mL prefilled syringe	Inject 20mg (2mL) intra-articularly once weekly for 3 weeks	Qty: ☐ 3 prefilled syringes ☐ 6 prefilled syringes Refills:________
☐ Visco-3 (hyaluronate sodium)	25mg/2.5mL prefilled syringe	Inject 25mg (2.5mL) intra-articularly once weekly for 3 weeks	Qty: ☐ 3 prefilled syringes ☐ 6 prefilled syringes Refills:________

Prescriber Name ________________________

Phone ________________ Fax ________________

Email Address ________________________

Office Address ________________________

City ________________ State ________ ZIP ____________

State License ____________ DEA ____________ NPI ____________

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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 ______________________