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

If yes, please indicate start date: ______________________

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

☐ NKDA ☐ Known drug allergies ______________________

Concurrent Medications ______________________

Prescribing Information

Medication	Strength	Directions	Qty/Refills
☐ Forteo (teriparatide)	600mcg/2.4mL pen	Inject 1 dose (20mcg) subcutaneously once daily. Discard device 28 days after 1st use. Stop Date:________	Qty: ☐ 1 pen ☐ 3 pens Refills:________
☐ Teriparatide	620mcg/2.48mL pen	Inject 1 dose (20mcg) subcutaneously once daily. Discard device 28 days after 1st use. Stop Date:________	Qty: ☐ 1 pen ☐ 3 pens Refills:________
☐ Prolia (denosumab)	60mg/mL prefilled syringe	Inject the contents of 1 syringe (60mg) subcutaneously every 6 months. To be administered by a healthcare professional.	Qty: 1 prefilled syringe Refills:________
☐ Reclast (zoledronic acid)	5mg/100mL vial	Infuse 5mg intravenously over no less than 15 minutes once annually	Qty: 1 vial Refills:________
☐ Ibandronate	3mg/3mL prefilled syringe	Inject the contents of 1 syringe (3mg) intravenously every 3 months. To be administered by a healthcare professional.	Qty: 1 prefilled syringe Refills:________
☐ Evenity (romosozumab-aqqg)	105mg/1.17ml prefilled syringes (Total dose = 210mg)	Inject the contents of 2 syringes (210 mg) one immediately after the other subcutaneously once monthly. To be administered by a healthcare professional.	Qty: ☐ 2 pack box of 105mg/1.17ml (Total dose = 210mg) ☐ Other:________ 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 ____________________