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 _____

giant eagle specialty pharmacy
SpecialtyRx.GiantEagle.com
1-844-259-1891

## 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 _____ Height: _____ cm Weight: _____ kg Date Recorded: _____

TB Test Results and Date: _____

Has Hepatitis B been ruled out? ☐ Yes ☐ No Date: _____

If No, has treatment been initiated? ☐ Yes ☐ No

☐ New therapy induction ☐ Therapy change

Other therapies tried and failed:

☐ Corticosteroids Date: _____

☐ Methotrexate Date: _____

☐ Hydroxychloroquine Date: _____

☐ Leflunomide Date: _____

☐ Azathioprine Date: _____

☐ Sulfazalazine Date: _____

☐ Other biologics _____ Date: _____

☐ Other _____ Date _____

Additional justification for drug _____

☐ NKDA ☐ Known drug allergies _____

Concurrent Medications _____

## Prescribing Information

| Medication | Strength | Directions | Qty/Refills |
|---|---|---|---|
| ☐ Actemra (tocilizumab) ***ADULT*** Patient weight _____kg | ☐ 162mg/0.9mL prefilled syringe<br>☐ 162mg/0.9mL pen | ☐ Inject 162mg subcutaneously every other week<br>☐ Inject 162mg subcutaneously every week | Qty:<br>☐ 2 devices<br>☐ 4 devices<br>☐ 6 devices<br>☐ 12 devices<br>Refills: _____ |
| ☐ Actemra (tocilizumab) ***PEDIATRIC*** Patient weight _____kg | ☐ 162mg/0.9mL prefilled syringe<br>☐ 162mg/0.9mL pen | ☐ Inject 162mg subcutaneously every three weeks<br>☐ Inject 162mg subcutaneously every two weeks | Qty:<br>_____devices<br>Refills: _____ |

giant eagle specialty pharmacy
SpecialtyRx.GiantEagle.com
1-844-259-1891

# Prescribing Information Cont.

| Medication | Strength | Directions | Qty/Refills |
|---|---|---|---|
| ☐ Cimzia (certolizumab pegol) | **Starter:**<br>☐ 200mg/mL prefilled syringes (1 kit = 6 syringes, 3 doses) | **Starter:**<br>Inject 400mg subcutaneously at weeks 0, 2, and 4 | Qty:<br>1 kit<br>Refills: 0 |
| | **Maintenance:**<br>☐ 200mg/mL prefilled syringes (total dose = 400mg) | **Maintenance:**<br>☐ Inject the contents of 2 syringes (400mg) subcutaneously every 4 weeks<br>☐ Inject the contents of 1 syringe (200mg) subcutaneously every 2 weeks | Qty:<br>☐ 2 syringes<br>☐ 6 syringes<br>Refills: _____ |
| ☐ Cosentyx (secukinumab)<br>***ADULT*** | ☐ 150mg/mL prefilled syringe<br>☐ 150mg/mL Sensoready auto-injector | **Starter:**<br>☐ Inject 150mg subcutaneously once weekly at week 0, 1, 2, 3, and 4, then 150mg every 4 weeks<br>☐ Inject 300mg subcutaneously once weekly at week 0, 1, 2, 3, and 4, then 300mg every 4 weeks | Qty:<br>☐ 5 devices<br>☐ 10 devices<br>Refills: 0 |
| | | **Maintenance:**<br>☐ Inject 150mg subcutaneously once every 4 weeks<br>☐ Inject 300mg subcutaneously once every 4 weeks | Qty:<br>☐ 1 device<br>☐ 2 devices<br>☐ 3 devices<br>☐ 6 devices<br>Refills: _____ |
| ☐ Cosentyx (secukinumab)<br>***PEDIATRIC***<br>Patient weight _____kg | ☐ 75mg/0.5mL prefilled syringe<br>☐ 150mg/mL Sensoready auto-injector<br>☐ 150mg/mL prefilled syringe | **Starter:**<br>☐ Inject 75mg subcutaneously once weekly at week 0, 1, 2, 3, and 4<br>☐ Inject 150mg subcutaneously once weekly at week 0, 1, 2, 3, and 4 | Qty:<br>5 devices<br>Refills: 0 |
| | | **Maintenance:**<br>☐ Inject 75mg subcutaneously once every 4 weeks<br>☐ Inject 150mg subcutaneously once every 4 weeks | Qty:<br>☐ 1 device<br>☐ 3 devices<br>Refills: _____ |
| ☐ Enbrel (etanercept) | ☐ 25mg/0.5mL vial<br>☐ 25mg/0.5mL prefilled syringe<br>☐ 50mg/mL prefilled syringe<br>☐ 50mg/mL Sureclick auto-injector<br>☐ 50mg/mL Mini Cartridge | ☐ Inject 50mg subcutaneously once weekly<br>☐ Other: _____<br>_____<br>_____ | Qty:<br>☐ 4 devices<br>☐ 12 devices<br>☐ Other:<br>Refills: _____ |

giant eagle specialty pharmacy
SpecialtyRx.GiantEagle.com
1-844-259-1891

# Prescribing Information Cont.

| Medication | Strength | Directions | Qty/Refills |
|---|---|---|---|
| ☐ Humira (adalimumab)<br>***ADULT*** | **Starter:**<br>**CITRATE FREE**<br>☐ **Psoriasis/Uveitis or adolescent HS Starter Kit** (1x 80mg/0.8mL and 2x 40mg/0.4mL) pen-injector<br>☐ **HS Starter Kit** (3x 80mg/0.8mL) pen-injector | **Psoriasis/Uveitis/adolescent HS Starter:**<br>☐ Inject 80mg as a single dose, then inject 40mg subcutaneously every other week beginning 1 week after the initial dose<br>**HS Starter:**<br>☐ Inject 160mg subcutaneously followed by 80mg subcutaneously 2 weeks later on Day 15 | Qty:<br>1 starter kit<br>Refills: 0 |
| | **Maintenance:**<br>**CITRATE FREE**<br>☐ 40mg/0.4mL pen-injector<br>☐ 40mg/0.4mL prefilled syringe<br>☐ 80mg/0.8mL pen-injector<br>**ORIGINAL FORMULATION**<br>☐ 40mg/0.8mL pen-injector<br>☐ 40mg/0.8mL prefilled syringe | **Maintenance:**<br>☐ Inject 40mg subcutaneously every other week<br>☐ Inject 40mg subcutaneously every week<br>☐ Inject 80mg subcutaneously every other week | Qty:<br>☐ 2 devices<br>☐ 6 devices<br>☐ Other (must be in multiples of 2)<br>Refills: _____ |
| ☐ Humira (adalimumab)<br>***PEDIATRIC***<br>Patient weight _____kg | **CITRATE FREE**<br>☐ 10mg/0.1mL prefilled syringe<br>☐ 20mg/0.2mL prefilled syringe<br>☐ 40mg/0.4mL pen-injector<br>☐ 40mg/0.4mL prefilled syringe | ☐ Inject 10mg subcutaneously every other week<br>☐ Inject 20mg subcutaneously every other week<br>☐ Inject 40mg subcutaneously every other week | Qty:<br>☐ 2 devices<br>☐ 6 devices<br>☐ Other (must be in multiples of 2)<br>Refills: _____ |
| ☐ Kevzara (sarilumab) | ☐ 200mg/1.14mL prefilled pen<br>☐ 200mg/1.14mL prefilled syringe<br>☐ 150mg/1.14mL prefilled pen<br>☐ 150mg/1.14mL prefilled syringe | ☐ Inject 200mg subcutaneously once every 2 weeks<br>☐ Inject 150mg subcutaneously once every 2 weeks | Qty:<br>☐ 2 devices<br>☐ 6 devices<br>Refills: _____ |
| ☐ Other: _____ | | | Qty: _____<br>Refills: _____ |

giant eagle specialty pharmacy
SpecialtyRx.GiantEagle.com
1-844-259-1891

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 _____