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 ____________ Height: ______ cm Weight: ______ kg Date Recorded: ____________

TB Test Results and Date: ____________________ CrCl: ____________ Date Recorded: ____________

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
☐ Olumiant (baricitinib)	☐ 1mg tablet ☐ 2mg tablet ☐ 4mg tablet	☐ Take 1 tablet by mouth once daily ☐ Other: ____________ ____________ ____________	Qty: ☐ 30 tablets ☐ 90 tablets Refills: ________
☐ Orencia (abatacept) ***ADULT***	☐ 125mg/mL ClickJect auto-injector ☐ 125mg/mL prefilled syringe	☐ Inject 125mg subcutaneously once weekly	Qty: ☐ 4 devices ☐ 12 devices Refills: ________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Orencia (abatacept) ***PEDIATRIC*** Patient weight ________ kg	☐ 50mg/0.4mL prefilled syringe ☐ 87.5mg/0.7mL prefilled syringe ☐ 125mg/mL prefilled syringe	☐ Inject 50mg subcutaneously once weekly ☐ Inject 87.5mg subcutaneously once weekly ☐ Inject 125mg subcutaneously once weekly	Qty: ☐ 4 devices ☐ 12 devices Refills: ________
☐ Otezla (apremilast) CrCl ____________	☐ **Starter:** 55 tablet Starter pack (consisting of 10mg-20mg-30mg tablets for 28 days)	**Starter:** Take as directed on package	Qty: 1 starter pack Refills: 0
	☐ **Maintenance:** 30mg tablet	**Maintenance:** ☐ Take 1 tablet by mouth twice daily ☐ Other: ____________	Qty: ☐ 60 tablets ☐ 180 tablets ☐ Other: ________ Refills: ________
☐ Remicade (infliximab) OR biosimilar ☐ Avsola (infliximab-axxq) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) Patient weight ________ kg	100mg vial	**Starter:** ☐ Infuse ______ mg (3mg/kg) intravenously at week 0, 2, and 6, then every 6 weeks thereafter ☐ Infuse ______ mg (5mg/kg) intravenously at week 0, 2, and 6, then every 6 weeks thereafter ☐ Infuse ______ mg (5mg/kg) intravenously at week 0, 2, and 6, then every 8 weeks thereafter ☐ Other: ____________	Qty: ______ vial(s) Refills:0
		Maintenance: ☐ Infuse ______ mg (3mg/kg) intravenously every 8 weeks ☐ Infuse ______ mg (5mg/kg) intravenously every 6 weeks ☐ Infuse ______ mg (5mg/kg) intravenously every 8 weeks ☐ Other: ____________	Qty: ______ vial(s) Refills: ________
☐ Rinvoq (upadacitnib)	15mg tablet	Take 15mg by mouth once daily	Qty: ☐ 30 tablets ☐ 90 tablets Refills: ________

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Rituxan OR biosimilar ☐ Truxima (rituximab-abbs) ☐ Ruxience (rituximab-pvvr) ☐ Riabni (rituximab-arrx)	100mg/10mL vial	☐ Administer 1 gram intravenously once every 2 weeks for 2 doses ☐ Other: ____________ ____________	Qty: ______ vial(s) Refills: ________
☐ Other: ____________			Qty: ________ Refills: ________

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 ______________