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 _____

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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: _____

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
☐ Simponi (golimumab)	☐ 50mg/0.5mL prefilled syringe ☐ 50mg/0.5mL SmartJect auto-injector	Inject 50mg subcutaneously once per month	Qty: ☐ 1 device ☐ 3 devices Refills: _____
☐ Simponi Aria (golimumab) ***ADULT*** Patient weight _____kg	50mg/4mL vial	**Starter:** ☐ Administer _____ mg (2mg/kg) intravenously at weeks 0, 4, then every 8 weeks thereafter	Qty: _____ vial(s) Refills: _____
		Maintenance: ☐ Administer _____ mg (2mg/kg) intravenously every 8 weeks	Qty: _____ vial(s) Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Simponi Aria (golimumab) ***PEDIATRIC*** Patient weight _____kg Patient height _____cm	50mg/4mL vial	**Starter:** ☐ Administer_____mg (80mg/m2) intravenously at weeks 0, 4, then every 8 weeks thereafter	Qty: _____ vial(s) Refills: _____
		Maintenance: ☐ Administer_____mg (80mg/m2) intravenously every 8 weeks	Qty: _____ vial(s) Refills: _____
☐ Skyrizi (risankizumumab) Patient weight _____kg	☐ 150mg/mL auto-injector ☐ 150mg/mL prefilled syringe	**Starter:** ☐ Inject 150mg subcutaneously at weeks 0, 4, and then every 12 weeks thereafter	Qty: 2 devices Refills: 0
		Maintenance: ☐ Inject 150mg subcutaneously every 12 weeks	Qty: 1 device Refills: _____
☐ Stelara (ustekinumab) Patient weight _____kg	☐ 45mg/0.5mL prefilled syringe ☐ 90mg/mL prefilled syringe	**Starter:** ☐ Inject 45mg subcutaneously at weeks 0,4, and then every 12 weeks thereafter ☐ Inject 90mg subcutaneously at weeks 0,4, and then every 12 weeks thereafter	Qty: 2 prefilled syringes Refills: 0
		Maintenance: ☐ Inject 45mg subcutaneously every 12 weeks ☐ Inject 90mg subcutaneously every 12 weeks	Qty: 1 prefilled syringe Refills: _____
☐ Taltz (ixekizumab)	☐ 80mg/mL autoinjector ☐ 80mg/mL prefilled syringe	**Ankylosing Spondylitis/ Psoriatic Arthritis Starter:** ☐ Inject 160mg (2 injections) subcutaneously once at week 0, followed by 80mg every 4 weeks	Qty: 2 devices Refills: 0
		Maintenance: ☐ Inject 80mg subcutaneously every 4 weeks	Qty: ☐ 1 device ☐ 3 devices Refills: _____
☐ Xeljanz (tofacitinib)	5mg tablet	Take 1 tablet by mouth twice daily	Qty: ☐ 60 tablets ☐ 180 tablets Refills: _____

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Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
☐ Xeljanz XR (tofacitinib)	11mg XR tablet	Take 1 tablet by mouth once daily	Qty: ☐ 30 XR tablets ☐ 90 XR tablets 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 _____