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 _____ Secondary Diagnosis _____

Has the patient been on this therapy before? ☐ Yes ☐ No

Date of last injection (if applicable) _____ DATE FIRST/NEXT INJECTION IS DUE _____

Is patient on dialysis? ☐ Yes ☐ No Patient weight _____kg Date recorded _____

Laboratory Results:

Hematocrit _____ % Date _____

Hemaglobin _____ g/dL Date _____

Platelets _____ cell/mm^3 Date _____

☐ NKDA ☐ Known drug allergies

_____

_____

Concurrent Medications:

_____

_____

_____

_____

_____

_____

Prescribing Information

Medication	Strength	Directions *(include frequency and duration of therapy)*	Qty/Refills
☐ Aranesp (darbepoetin alfa)	_____ Singleject _____ vial	Inject _____ mcg subcutaneously _____	Qty: _____ Refills _____
☐ Epogen (epoetin alfa)		Inject _____ units subcutaneously _____	Qty: _____ Refills _____
☐ Procrit (epoetin alfa)		Inject _____ units subcutaneously _____	Qty: _____ Refills _____
☐ Retacrit (epoetin alfa-epbx)		Inject _____ units subcutaneously _____	Qty: _____ Refills _____
☐ Other: _____ _____			Qty: _____ Refills _____

Prescriber Name _____

Phone _____ Fax _____

Email Address _____

Office Address _____

City _____ State _____ ZIP _____

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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 _____