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: _____ 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: _____

☐ Sulfasalazine 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 _____