



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 _____

Patient's Name

First _____ Last _____ MI _____

Date of Birth _____

Primary ICD-10 code _____ Has the patient been on this therapy before? Yes No

Date of last injection (if applicable) _____ **DATE OF FIRST/NEXT INJECTION** _____

If patient is new to injectable therapy, did the patient have an oral trial of the medication?

Yes No If yes: Medication _____ Date _____ Length of oral therapy _____

NKDA Known drug allergies _____

Concurrent Medications _____

Prescribing Information

Medication	Strength	Directions	Qty/Refills
<input type="checkbox"/> Abilify Maintena (aripiprazole)	<input type="checkbox"/> 300mg dual chamber syringe <input type="checkbox"/> 300mg powdered vial <input type="checkbox"/> 400mg dual chamber syringe <input type="checkbox"/> 400mg powdered vial	<input type="checkbox"/> Inject 300mg intramuscularly once monthly <input type="checkbox"/> Inject 400mg intramuscularly once monthly	Qty: 1 kit Refills: _____
<input type="checkbox"/> Aristada (aripiprazole lauroxil)	<input type="checkbox"/> 441mg/1.6mL prefilled syringe <input type="checkbox"/> 662mg/2.4mL prefilled syringe <input type="checkbox"/> 882mg/3.2mL prefilled syringe <input type="checkbox"/> 1064mg/3.9mL prefilled syringe	<input type="checkbox"/> Inject 441mg intramuscularly once monthly <input type="checkbox"/> Inject 662mg intramuscularly once monthly <input type="checkbox"/> Inject 882mg intramuscularly once monthly <input type="checkbox"/> Inject 882mg intramuscularly every 6 weeks <input type="checkbox"/> Inject 1064mg intramuscularly every 2 months	Qty: 1 prefilled syringe Refills: _____
<input type="checkbox"/> Aristada Initio (aripiprazole lauroxil)	675mg/2.4mL prefilled syringe	Inject 675mg intramuscularly once	Qty: 1 prefilled syringe Refills: 0
<input type="checkbox"/> Invega Hafyera (paliperidone palmitate)	<input type="checkbox"/> 1092mg/3.5mL prefilled syringe <input type="checkbox"/> 1560mg/5mL prefilled syringe	Inject the contents of 1 syringe intramuscularly every 6 months	Qty: 1 prefilled syringe Refills: _____
<input type="checkbox"/> Invega Sustenna (paliperidone palmitate)	Starter: <input type="checkbox"/> 234mg/1.5mL prefilled syringe	Starter: Inject 234mg intramuscularly on day 1 into the deltoid muscle	Starter: Qty: 1 prefilled syringe Refills: 0
	Dose 2: <input type="checkbox"/> 156mg/mL prefilled syringe	Dose 2: Inject 156mg intramuscularly into the deltoid muscle 1 week after 234mg injection	Dose 2: Qty: 1 prefilled syringe Refills: 0
	Maintenance: <input type="checkbox"/> 39mg/0.25mL prefilled syringe <input type="checkbox"/> 78mg/0.5mL prefilled syringe <input type="checkbox"/> 117mg/0.75mL prefilled syringe <input type="checkbox"/> 156mg/mL prefilled syringe <input type="checkbox"/> 234mg/1.5mL prefilled syringe	Maintenance: Inject the contents of 1 syringe intramuscularly every month	Maintenance: Qty: 1 prefilled syringe Refills: _____

Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
<input type="checkbox"/> Invega Trinza (paliperidone palmitate)	<input type="checkbox"/> 273mg/0.875mL prefilled syringe <input type="checkbox"/> 410mg/1.315mL prefilled syringe <input type="checkbox"/> 546mg/1.75mL prefilled syringe <input type="checkbox"/> 819mg/2.625mL prefilled syringe	Inject the contents of 1 syringe intramuscularly every 3 months	Qty: 1 prefilled syringe Refills: _____
<input type="checkbox"/> Perseris (risperidone)	<input type="checkbox"/> 90mg prefilled syringe <input type="checkbox"/> 120mg prefilled syringe	<input type="checkbox"/> Inject 90mg subcutaneously once monthly <input type="checkbox"/> Inject 120mg subcutaneously once monthly	Qty: 1 prefilled syringe Refills: _____
<input type="checkbox"/> Risperdal Consta (risperidone)	<input type="checkbox"/> 12.5mg vial kit <input type="checkbox"/> 25mg vial kit <input type="checkbox"/> 37.5mg vial kit <input type="checkbox"/> 50mg vial kit	<input type="checkbox"/> Inject 25mg intramuscularly every 2 weeks <input type="checkbox"/> Inject 37.5mg intramuscularly every 2 weeks <input type="checkbox"/> Inject 50mg intramuscularly every 2 weeks Other: _____	Qty: <input type="checkbox"/> 1 kit <input type="checkbox"/> 2 kits <input type="checkbox"/> Other: Refills: _____
<input type="checkbox"/> Uzedy (risperidone)	<input type="checkbox"/> 50mg/0.14ml prefilled syringe <input type="checkbox"/> 75mg/0.21ml prefilled syringe <input type="checkbox"/> 100mg/0.28ml prefilled syringe <input type="checkbox"/> 125mg/0.35ml prefilled syringe <input type="checkbox"/> 150mg/0.42ml prefilled syringe <input type="checkbox"/> 200mg/0.56ml prefilled syringe <input type="checkbox"/> 250mg/0.7ml prefilled syringe	<input type="checkbox"/> Inject 50mg subcutaneously once monthly <input type="checkbox"/> Inject 75mg subcutaneously once monthly <input type="checkbox"/> Inject 100mg subcutaneously once monthly <input type="checkbox"/> Inject 125mg subcutaneously once monthly <input type="checkbox"/> Inject 100mg subcutaneously every 2 months <input type="checkbox"/> Inject 125mg subcutaneously every 2 months <input type="checkbox"/> Inject 150mg subcutaneously every 2 months <input type="checkbox"/> Inject 200mg subcutaneously every 2 months <input type="checkbox"/> Inject 250mg subcutaneously every 2 months	Qty: <input type="checkbox"/> 1 device <input type="checkbox"/> 3 devices Refills: _____
<input type="checkbox"/> Other: _____ _____			Qty: _____ Refills: _____

Prescriber Name _____

Phone _____ Fax _____

Email Address _____

Office Address _____

City _____ State _____ ZIP _____

State License _____ DEA _____ NPI _____

I hereby authorize Giant Eagle to contact my prescribing provider to coordinate the delivery, receipt, and storage of my prescription medication for the sole purpose of administration by my provider at my next scheduled appointment. Signature serves as Patient Ship Authorization.

Patient authorization _____

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 _____