



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 _____ Secondary diagnosis _____

Has the patient been on this therapy before? Yes No

Date of Last injection _____ Date of first/next injection _____

Patient Height _____ cm Weight _____ kg BSA _____ Date recorded: _____

Laboratory results:

WBC _____ cell/mm³ Date _____

ANC _____ cell/mm³ Date _____

Platelets _____ cell/mm³ Date _____

NKDA Known drug allergies _____

Concurrent Medications _____

Prescribing Information

Medication	Strength	Directions MUST INCLUDE DAILY, WEEKLY, CYCLIC, ONE-TIME, and DURATION OF THERAPY	Qty/Refills
<input type="checkbox"/> Fulphila (pegfilgrastim-jmdb)	6mg/0.6mL prefilled syringe	Administer 6mg subcutaneously _____ _____ Cycle length: _____	Qty: _____ Refills: _____
<input type="checkbox"/> Granix (tbo-filgrastim)	<input type="checkbox"/> 300mcg/mL vial <input type="checkbox"/> 300mcg/0.5mL prefilled syringe <input type="checkbox"/> 480mcg/1.6mL vial <input type="checkbox"/> 480mcg/0.8mL prefilled syringe	Administer _____ mcg <input type="checkbox"/> subcutaneously <input type="checkbox"/> intravenously _____ _____ Cycle length: _____	Qty: _____ Refills: _____
<input type="checkbox"/> Leukine (sargramostim)	250mcg vial	Administer _____ mcg <input type="checkbox"/> subcutaneously <input type="checkbox"/> intravenously _____ _____ Cycle length: _____	Qty: _____ Refills: _____

Prescribing Information Cont.

Medication	Strength	Directions	Qty/Refills
<input type="checkbox"/> Neupogen (filgrastim)	<input type="checkbox"/> 300mcg/mL vial <input type="checkbox"/> 300mcg/0.5mL SingleJect prefilled syringe <input type="checkbox"/> 480mcg/1.6mL vial <input type="checkbox"/> 480mcg/0.8mL SingleJect prefilled syringe	Administer _____ mcg <input type="checkbox"/> subcutaneously <input type="checkbox"/> intravenously _____ _____ Cycle length: _____	Qty: _____ Refills: _____
<input type="checkbox"/> Neulasta (pegfilgrastim)	6mg/0.6mL prefilled syringe	Administer 6mg subcutaneously _____ _____ Cycle length: _____	Qty: _____ Refills: _____
<input type="checkbox"/> Neulasta Onpro (pegfilgrastim)	6mg/0.6mL Onpro On-body injector Kit	Administer 6mg subcutaneously every _____ days as directed. To be applied by a healthcare professional. Cycle length: _____	Qty: _____ Refills: _____
<input type="checkbox"/> Nivestym (filgrastim-aafi)	<input type="checkbox"/> 300mcg/mL vial <input type="checkbox"/> 300mcg/0.5mL prefilled syringe <input type="checkbox"/> 480mcg/1.6mL vial <input type="checkbox"/> 480mcg/0.8mL prefilled syringe	Administer _____ mcg <input type="checkbox"/> subcutaneously <input type="checkbox"/> intravenously _____ _____ Cycle length: _____	Qty: _____ Refills: _____
<input type="checkbox"/> Udenyca (pegfilgrastim-cbqv)	<input type="checkbox"/> 6mg/0.6mL prefilled syringe <input type="checkbox"/> 6mg/0.6mL auto-injector	Administer 6mg subcutaneously _____ _____ Cycle length: _____	Qty: _____ Refills: _____
<input type="checkbox"/> Zarxio (filgrastim-sndz)	<input type="checkbox"/> 300mcg/0.5mL prefilled syringe <input type="checkbox"/> 480mcg/0.8mL prefilled syringe	Administer _____ mcg subcutaneously _____ _____ Cycle length: _____	Qty: _____ Refills: _____
<input type="checkbox"/> 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 _____