Giant Eagle Specialty Pharmacy

Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

COSENTYX® ENROLLMENT FORM

Today's Date: _____

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**_____ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: _____ ☐ Male ☐ Female DOB: _____
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Best Phone #: _____ Alternate Phone #: _____
Weight: _____ ☐ kgs. or ☐ lbs. Caregiver: _____ Allergies: _____
Store Preference (address): _____
TB/PPD Test Given? ☐ Yes ☐ No Negative TB Test & Date: _____
Emergency Contact Name:_____ Emergency Contact Phone #: _____

Insurance Information: Please fax copy of insurance card (front + back)

Clinical Information

DIAGNOSIS/ ICD-10 _____
☐ Psoriasis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis

TREATMENT HISTORY:
☐ To my knowledge, the patient has not previously been treated with a biologic for the diagnosed condition.

If patient has been treated with a biologic, please provide information below.
Does this patient have a contraindication, intolerance, or allergy to Enbrel®, Humira®, Remicade®, Stelara®, Cimzia®, Simponi®, Taltz®, or other biologic treatment?
☐ Yes ☐ No _____

Does this patient have documented failure of adequate trial on Enbrel®, Humira®, Remicade®, Stelara®, Cimzia®, Simponi®, Taltz®, or other biologic treatment?
☐ Yes ☐ No _____

If YES, please indicate which drug(s) and date(s) of usage.
Enbrel® From: _____ To: _____ Humira® From: _____ To: _____
Remicade® From: _____ To: _____ Stelara® From: _____ To: _____
Cimzia® From: _____ To: _____ Simponi® From: _____ To: _____
Taltz® From: _____ To: _____ Other From: _____ To: _____

Prior (FAILED) Medications:

	Medications	Date
Biologics		
Methotrexate		
Oral Meds		
PUVA		
UVB		
Topicals		
Other		

Additional justification for drug _____
_____

Prescription

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cosentyx® (secukinumab)	☐ 150mg/mL Sensoready® Pen	☐ Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3	#4	_____
	☐ 150mg/mL Prefilled Syringe	☐ Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	#8	_____
	☐ 150mg/mL Sensoready® Pen	☐ Inject 150 mg subcut once weekly at week 4 and every 4 weeks thereafter	#1	_____
	☐ 150mg/mL Prefilled Syringe	☐ Inject 300 mg subcut once weekly at week 4 and every 4 weeks thereafter	#2	_____

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____ DEA #: _____

In order for a brand name to be dispensed, the 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.

Physician Signature: _____ **Date:** _____