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

DERMATOLOGY 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 ☐ Atopic Dermatitis ☐ _____
Does patient have a latex allergy? ☐ Yes ☐ No Other Comments _____
_____% BSA (Body Surface Area) affected by Psoriasis
Patient complains of joint pain, developing PsA ☐ Yes ☐ No
Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No
If No, has treatment been initiated? ☐ Yes ☐ No
Main contraindication for systemic use: Alcohol use: ☐ Yes ☐ No
Childbearing age: _____ Elevated Liver Enzymes: ☐ Yes ☐ No

Prior (FAILED) Medications:

	Medications	Date
Biologics		
Methotrexate		
Oral Meds		
PUVA		
UVB		
Topicals		
Other		

Additional justification for drug _____

Prescription

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia® *Only for PsA	**Starter Dose** ☐ Starter Kit (200mg Prefilled Syringes)	☐ 400mg Sub-Q at weeks 0, 2 and 4	☐ 1 Kit = 6 x 200mg/mL PFS ☐ 3 Kits = 3 cartons of 2 x 200mg Vials	NO refills _____
	Maintenance Dose ☐ 200mg/ml Prefilled Syringe	☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200mg/mL PFS	_____ _____
☐ Cosentyx® (secukinumab)	**Starter Dose** ☐ 150mg/mL Sensoready® Pen ☐ 150mg/mL Prefilled Syringe	☐ Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3 ☐ Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	#4 #8	_____ _____
	Maintenance Dose ☐ 150mg/mL Sensoready® Pen ☐ 150mg/mL Prefilled Syringe	☐ Inject 150 mg subcut once weekly at week 4 and every 4 weeks thereafter ☐ Inject 300 mg subcut once weekly at week 4 and every 4 weeks thereafter	#1 #2	_____ _____
☐ Dupixent (dupilumab) ** Only for Atopic Dermatitis*	☐ 300mg/2mL Prefilled Syringe	☐ **INITIAL DOSAGE:** Inject 600mg SQ on Day 1 (given as two 300mg injections) ☐ **MAINTENANCE DOSAGE**: Starting on Day 15, inject 300mg SQ once every other week	#2 #2	_____ _____
☐ Enbrel®	☐ 50mg/mL SureClick® Autoinjector ☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL mini pre-filled cartridge	☐ **Psoriasis Induction Dose:** Inject 50mg SC TWICE a week (72-96 hours apart) x 3 months ☐ Inject 50mg SC ONCE a week	3-month supply 4-week supply	NO refills _____
Humira® ☐ Psoriasis Starter kit ☐ **HS STARTER KIT** ☐ Pen ☐ Pre-filled Syringe	☐ 40mg/0.4ml Prefilled Auto Pen ☐ 40mg/0.4ml Prefilled Syringes	☐ **INITIAL DOSAGE:** Inject 80mg SQ on Day 1, 40mg on Day 8, then 40mg QOW ☐ **INITIAL DOSAGE:** Inject 160mg SQ on Day 1, then 80mg on Day 15 ☐ **MAINTENANCE**: Inject 40mg SQ QOW ☐ **MAINTENANCE**: Inject 40mg SQ QW	#4 #3 #2 #4	

Continued on reverse side >>

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Prescription

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Otezla®	**Starter Dose** ☐ Starter Dose (Four Week Starter Pack)	☐ **Day 1:** 10mg a.m.; **Day 2:** 10mg a.m., 10mg p.m.; **Day 3:** 10mg a.m., 20mg p.m.; **Day 4:** 20mg a.m., 20mg p.m.; **Day 5:** 20mg a.m., 30mg p.m.; **Day 6 and thereafter:** 30mg twice daily (as indicated on starter packaging)	☐ 1 four week starter pack	NO refills _____
	Maintenance Dose ☐ 30mg Tablet	☐ 30mg twice daily ☐ Other_____	☐ 60 tablets	
☐ Remicade® ☐ Inflectra	☐ 100mg Vial	☐ **INDUCTION DOSE:** IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks (ICD-10: 714.0, 696.0, & 720.0) ☐ **MAINTENANCE DOSE:** IV in 250ml of 0.9% NaCl every 8 weeks (ICD-10: 714.0 & 696.0) ☐ **MAINTENANCE DOSE:** IV in 250ml of 0.9% NaCl every 6 weeks (ICD-10: 720.0) ☐ **Other:**		
☐ Simponi® *Only for PsA	☐ 50mg/0.5ml SmartJect™ Autoinjector ☐ 50mg/0.5mL Prefilled Syringe	☐ Inject 1 single-use Autoinjector SC once monthly ☐ Inject 1 single-use Prefilled Syringe SC once monthly	1 (one)	_____
☐ Stelara®	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/1mL Prefilled Syringe	☐ **INITIATION DOSE:** Inject the contents of 1 prefilled syringe SC initially Day 1 ☐ **MAINTENANCE DOSE:** Inject the contents of 1 prefilled syringe SC starting Day 29 & every 12 weeks thereafter	Qty: 1 _____	NO refills _____
☐ Taltz	☐ 80 mg/1mL Autoinjector 00002-1445-11 (1 pack) ☐ 80 mg/1mL Autoinjector 00002-1445-27 (2 pack) ☐ 80 mg/1mL Prefilled Syringe 00002-7724-11 (1 pack)	**PLAQUE PSORIASIS:** ☐ **INDUCTION DOSE:** 160 mg subcutaneously at week 0, followed by 80 mg subcutaneously at weeks 2, 4, 6, 8, 10, and 12. ☐ **MAINTENANCE DOSE:** 80 mg subcutaneously every 4 weeks.	#8 #1	NO refills _____
		PSORIATIC ARTHRITIS: ☐ **INDUCTION DOSE:** 160 mg subcutaneously at week 0, followed by 80 mg subcutaneously every 4 weeks. ☐ **MAINTENANCE DOSE:** 80 mg subcutaneously every 4 weeks.	#2 #1	NO refills _____
☐ Tremfya™	**Starter Dose** ☐ 100 mg x 2 prefilled syringes	☐ **INITIATION DOSE:** 100 mg sub-q at weeks 0,4	Qty: 2	NO refills _____
	Maintenance Dose ☐ 100 mg prefilled syringe	☐ **MAINTENANCE DOSE:** 100 mg sub-q every 8 weeks	Qty: 1	

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:** _____