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

RHEUMATOLOGY A-E 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

DIAGNOSIS / ICD-10: ____________ ☐ M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement ☐ L40.59 Psoriatic Arthritis ☐ M05.89 Other rheumatoid arthritis with rheumatoid factor of multiple sites ☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites ☐ M45.9 Ankylosing Spondylitis ☐ M06.89 Other specified rheumatoid arthritis, multiple sites ☐ Anatomical site: Shoulder - 1 Elbow - 2 Wrist - 3 Hand - 4 Hip - 5 Knee - 6 Ankle and foot - 7 Vertebrae - 8 Laterality: Right - 1 Left – 2
☐ Other: ____________ Date of Diagnosis or Years with Disease: ____________

Prior medication: ☐ Acetaminophen, ibuprofen, naproxen sodium, or other OTC pain relievers ☐ Humira® ☐ Enbrel®
☐ Calcipotriene ☐ Celebrex® ☐ Corticosteroids ☐ Indocin ☐ Methotrexate ☐ Naproxen ☐ Azulfidine
☐ ____________ Additional justification for drug: ____________

Other Clinical Information/Comments: General: Is patient also taking methotrexate? ☐ Yes ☐ No
Does patient have a latex allergy? ☐ Yes ☐ No
Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No If No, has treatment been initiated? ☐ Yes ☐ No

Prescription

MEDICATIONS	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Actemra®	☐ 162 mg/0.9 mL PFS ☐ Vials	☐ 162 mg Sub-Q every other week ☐ 162 mg Sub-Q once a week ☐ IV: Infuse ________mg via IV every 4 weeks	☐ 2 PFS ☐ 4 PFS ☐ ________	
☐ Cimzia®	**Starter Dose** ☐ 200mg/ml Prefilled Syringe Starter Kit NDC: 50474-0710-81 ☐ 200mg Lyophilized Powder (LYO)	Initial dose of 400mg SC at weeks 0, 2, and 4	1 Kit 3 Kits	0 0
	Maintenance Dose ☐ 200mg/ml Prefilled Syringe ☐ 200mg Lyophilized Powder (LYO)	☐ 400mg SC every 4 weeks ☐ 200mg SC every 2 weeks	4-weeks 3 months	________ ________
☐ Cosentyx®	**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	
☐ Enbrel®	☐ 50mg/ml Sureclick™ Autoinjector ☐ 50mg/ml Prefilled Syringe (PFS) ☐ 25mg Vial (inj. supplies incl) ☐ 50mg/mL mini pre-filled cartridge	☐ Inject 50mg SC ONCE a week ☐ ____________ ☐ Inject 25mg SC TWICE a week	4-weeks 3 months	________ ________

Prescriber Information

Date prescription needed: ____________
Physician Name (please print): ____________ Contact Name: ____________
Phone #: ____________ Fax #:____________ NPI #: ____________ Tax ID #: ____________
Office Address: ____________ City: ____________ State: ______ ZIP: ____________

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:** ____________