



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 R-S
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
<input type="checkbox"/> Remicade® <input type="checkbox"/> Inflectra	<input type="checkbox"/> 100mg Vial Dose to administer _____	<input type="checkbox"/> Induction Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks. (ICD-10: 714.0, 696.0, & 720.0) <input type="checkbox"/> Maintenance Dose: IV in 250ml of 0.9% NaCl every 8 weeks. (ICD-10: 714.0 & 696.0) <input type="checkbox"/> Maintenance Dose: IV in 250ml of 0.9% NaCl every 6 weeks. (ICD-10: 720.0) <input type="checkbox"/> Other: _____	6 weeks 8 weeks Other _____	_____ _____ _____
<input type="checkbox"/> Rituxan® IV	<input type="checkbox"/> 500mg/5ml vial. Dispense _____ vials	<input type="checkbox"/> Infuse 1000mg via IV on day 1 and day 15, then as directed	_____	_____
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5ml SmartJect™ Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 1 single-use SmartJect® Autoinjector SC once monthly <input type="checkbox"/> Inject 1 single-use Prefilled Syringe SC once monthly	1 (one) 3 months	_____ _____
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5mL Prefilled Syringe <input type="checkbox"/> 90mg/1mL Prefilled Syringe	<input type="checkbox"/> Initiation Dose: Inject the contents of 1 prefilled syringe SC initially Day 1 <input type="checkbox"/> Maintenance Dose: Inject the contents of 1 prefilled syringe SC starting Day 29 & every 12 weeks thereafter	Qty: 1 _____ 3 months	_____ NO refills

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:** _____