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

STELARA 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 Number: _____ Alternate Phone Number: _____
Best E-mail Address: _____
Height:_____ Weight: _____ ☐ kgs. or ☐ lbs. Recorded Date: _____
Caregiver: _____ Allergies: _____
Store Preference (address): _____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

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

Carrier: _____ PCN #: _____ Group: _____
Card: _____ BIN: _____

Prescription Information

MEDICATION	QUANTITY	REFILLS
IV ADMINISTRATION/INFUSION SUPPLIES		
☐ 0.9% sodium chloride infusion bag	275 mL	_____
☐ Rate Flow Regulator IV Set	1	_____
☐ Filtered extension set with 0.2 micrometer filter	1	_____
☐ Other: _____	_____	_____
PREMEDICATION ORDERS		
☐ None	_____	_____
☐ Acetaminophen 650 mg PO 30 minutes prior to infusion	_____	_____
☐ Diphenhydramine	_____	_____
☐ 50 mg PO 30 minutes prior to infusion ☐ 25 mg PO 30 minutes prior to infusion	_____	_____
☐ 50 mg IVP 30 minutes prior to infusion ☐ 25 mg IVP 30 minutes prior to infusion	_____	_____
☐ Methylprednisolone	_____	_____
☐ 40 mg IVP 30 minutes prior to infusion ☐ 125 mg IVP 30 minutes prior to infusion	_____	_____
☐ Other: _____	_____	_____
FLUSHING ORDERS		
☐ 0.9% sodium chloride 10 mL IV flush syringe: flush tubing with _____ mLs before and after medication and IVP for maintenance	_____	_____
☐ Other: _____	_____	_____
HYPERSENSITIVITY/ANAPHYLAXIS ORDERS		
☐ None	_____	_____
☐ Epinephrine 1 mg/mL ampule: administer 0.3-0.5 mL IM or subcutaneously, repeat every 5 to 10 minutes as necessary for anaphylaxis	_____	_____
☐ Diphenhydramine 50 mg slow IVP as needed for urticaria, pruritis, or SOB. Administer IM if there is no IV access.	_____	_____
☐ Methylprednisolone 125 mg slow IVP as needed for urticaria, pruritis, or SOB. Administer IM if there is no IV access.	_____	_____
☐ Other: _____	_____	_____

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____ Tax ID#: _____
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:** _____