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

DIFICID® 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: _____
Height:_____ Weight: _____ ☐ kgs. or ☐ lbs. Recorded Date: _____
Caregiver: _____ Caregiver Contact Number: _____
Allergies: _____
Store Preference (address): _____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

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

Primary Insurance: _____ Phone: _____
Policy #: _____ Medicare Effective Date #: _____

Clinical Info.

Has patient been treated previously for this condition? ☐ Yes ☐ No
Medication(s): _____

Is patient currently on therapy? ☐ Yes ☐ No
Medication(s): _____

Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No
If yes: How long should patient wait before starting the new medication?
_____

Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):_____

Primary Diagnosis: (ICD-10 Code & Description) _____

☐ 008.45 Intestinal infection due to Clostridium difficile ☐ Other_____

Date of diagnosis: _____

Prescription

MEDICATION	DIRECTIONS	QTY	REFILLS
☐ **Dificid 200mg tablet** Alt dose: _____	SIG: One 200mg tablet by mouth twice daily for 10 days with or without food.	20 _____	0 _____

Prescriber Information

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

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:** _____