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

ONCOLOGY 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: _____ **DIAGNOSIS DESCRIPTION:** _____ **ICD10:** _____ DOB:_____
☐ Adult Male ☐ Child Male ☐ Adult Female — Non Childbearing ☐ Adult Female — Childbearing
☐ Child Female — Non Childbearing ☐ Child Female — Childbearing
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City/County: _____ State: _____ ZIP: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Height:_____ Weight: _____ ☐ kgs. or ☐ lbs. Recorded Date: _____
Allergies: _____
Store Preference (address): _____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

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

Prescription

ORAL ONCOLYTICS

- Afinitor ☐
- Arimidex ☐
- Aromasin® ☐
- Casodex ☐
- Cyclophosphamide ☐
- Etoposide ☐
- Fareston ☐
- Femara ☐
- Flutamide ☐
- Gleevec® ☐
- Hycamtin® ☐
- Hydrea ☐
- Kisqali ☐
  - 200mg ☐
  - 400mg ☐
  - 600mg ☐
- Lonsurf*** ☐
  - 15mg/6.14mg ☐
  - 20mg/8.19mg ☐
- Lupron Depot ☐
- Mekinist ☐
- Rydapt ☐
- Sprycel® ☐
- Tafinlar ☐
- Tamoxifen ☐
- Tarceva® ☐
- Targretin® ☐
- Tasigna® ☐
- Temodar® ☐
- Tykerb ☐
- Votrient ☐
- Xeloda® ☐
- Zolinza ☐
  - .25 mg #___ ☐
  - 1 mg #___ ☐
- Zytiga ☐

Dosing & SIG:

Quantity: _____ Refill #: _____

**Authorization #: _____

***Recommended dose: 35 mg/m2/dose orally twice daily on Days 1 through 5 and Days 8 through 12 of each 28-day cycle. Round dose to the nearest 5 mg increment.

SUPPORT DRUGS

- Emend ☐
- Zofran ☐
- Sancuso ☐
- Aranesp® ☐
- Granix® ☐
- Neupogen® ☐
- Arixtra ☐
- Lovenox® ☐
- Procrit® ☐
- Caphosol ☐
- Neulasta® ☐
- Promacta ☐

Dosing & SIG:

IV MEDICATION

Darzalex IV 16mg/kg ☐
As directed Dispense Vials 100mg/mL #_____

Onivyde IV ☐
As directed Dispense Vials 43mg/mL #_____

Refill #: _____

Call for ordering procedure

Qutenza® ☐ Qty: _____ (up to 4 patches)
☐ WITH Lidocaine 4% cream
☐ WITH Prilocaine 2.5%/Lidocaine 2.5% cream

Complete this section ONLY if you would like Giant Eagle Specialty Pharmacy to initiate a Prior Authorization or Appeal on your behalf:

Previous Therapies

PRIOR THERAPY DRUG	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
	☐ Disease Progression ☐ Finished Therapy ☐ Toxicity _____	_____ _____

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:** _____