



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

**SIVEXTRO™
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
Information**

History of therapies tried/failed:

Culture Results:

Primary Diagnosis:

ICD10: _____ Other _____
Date of diagnosis: _____

Prescription

MEDICATION	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Sivextro™ 200mg tablet	SIG: 200mg by mouth once daily	_____	_____

**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:** _____