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

TRANSPLANT 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.

Diagnosis/ICD-10: _____
Transplant Date: _____ Anticipated Discharge Date:_____
Organ Transplanted: _____ Actual Discharge Date: _____

Prescription

Medication	Dose / Strength	SIG	Qty	Refills
☐ Tacrolimus®	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ Mycophenolate Mofetil	☐ 250mg ☐ 500mg ☐ 200mg/ml			
☐ Cyclosporine	☐ 25mg ☐ 100mg			
☐ Myfortic (Mycophenolic acid)	☐ 180mg ☐ 360mg			
☐ Rapamune (Sirolimus)	☐ 0.5mg ☐ 1mg ☐ 2mg ☐ 1mg/ml			
☐ Zortress	☐ 0.25mg ☐ 0.5mg ☐ 0.75mg			
☐ Azathioprine	☐ 50mg			
☐ Prednisone		☐ Taper as directed Other: _____		
☐ Prednisolone				
☐ Astagraf XL	☐ 0.5mg ☐ 1mg ☐ 5mg			
☐ Valcyte™ (Valganciclovir)	☐ 450mg ☐ 50mg/ml			
☐ Acyclovir	☐ 200mg ☐ 400mg ☐ 800mg ☐ 200mg/5ml			
☐ Clotrimazole	☐ 10mg Troches			
☐ Bactrim (Smz/Tmp)	☐ 800mg/160mg (DS) ☐ 400/80mg (SS)			
☐ Protonix (pantoprazole)	☐ 40mg ☐ 20mg			
☐ Lidocaine 5% Patch	☐ 700mg/patch (5%)	Apply____ Patch Daily As Needed		
☐ Furosemide	☐ 20mg ☐ 40mg			
☐ Other				
☐ Other				
☐ Other				

PLEASE WRITE "DAW" NEXT TO MEDICATION NAME IN THE EVENT PRESCRIBER DESIRES BRAND ONLY DISPENSING.

Equipment: _____ ☐ Transplant Kit (BP Monitor & Cuff, Therm. Pill Cutter & Box) Indicate Cuff Size: (S__) (M__) (L__) ☐ Scale

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:** _____