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

RHEUMATOLOGY R-S 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 #: _____ Alternate Phone #: _____
Weight: _____ ☐ kgs. or ☐ lbs. Caregiver: _____ Allergies: _____
Store Preference (address): _____
TB/PPD Test Given? ☐ **Yes** ☐ **No** **Negative TB Test & Date:** _____
Emergency Contact Name:_____ Emergency Contact Phone #: _____

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

Clinical

DIAGNOSIS / ICD-10: _____ ☐ M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement ☐ L40.59 Psoriatic Arthritis ☐ M05.89 Other rheumatoid arthritis with rheumatoid factor of multiple sites ☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites ☐ M45.9 Ankylosing Spondylitis
☐ M06.89 Other specified rheumatoid arthritis, multiple sites ☐ Anatomical site: Shoulder - 1 Elbow - 2 Wrist - 3 Hand - 4 Hip - 5 Knee - 6 Ankle and foot - 7 Vertebrae - 8 Laterality: Right - 1 Left – 2
☐ Other: _____ Date of Diagnosis or Years with Disease: _____

Prior medication: ☐ Acetaminophen, ibuprofen, naproxen sodium, or other OTC pain relievers ☐ Humira® ☐ Enbrel®
☐ Calcipotriene ☐ Celebrex® ☐ Corticosteroids ☐ Indocin ☐ Methotrexate ☐ Naproxen ☐ Azulfidine
☐ _____ Additional justification for drug: _____

Other Clinical Information/Comments: General: Is patient also taking methotrexate? ☐ Yes ☐ No
Does patient have a latex allergy? ☐ Yes ☐ No
Has Hepatitis B been ruled out or treatment been initiated? ☐ Yes ☐ No If No, has treatment been initiated? ☐ Yes ☐ No

Prescription

MEDICATIONS	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Remicade® ☐ Inflectra	☐ 100mg Vial Dose to administer_____	☐ Induction Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks. (ICD-10: 714.0, 696.0, & 720.0) ☐ Maintenance Dose: IV in 250ml of 0.9% NaCl every 8 weeks. (ICD-10: 714.0 & 696.0) ☐ Maintenance Dose: IV in 250ml of 0.9% NaCl every 6 weeks. (ICD-10: 720.0) ☐ Other: _____	6 weeks 8 weeks Other ____	_____
☐ Rituxan® IV	☐ 500mg/5ml vial. Dispense _____vials	☐ Infuse 1000mg via IV on day 1 and day 15, then as directed		_____
☐ Simponi®	☐ 50mg/0.5ml SmartJect™ Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 1 single-use SmartJect® Autoinjector SC once monthly ☐ Inject 1 single-use Prefilled Syringe SC once monthly	1 (one) 3 months	_____ _____
☐ Stelara®	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/1mL Prefilled Syringe	☐ Initiation Dose: Inject the contents of 1 prefilled syringe SC initially Day 1 ☐ Maintenance Dose: Inject the contents of 1 prefilled syringe SC starting Day 29 & every 12 weeks thereafter	Qty: 1 _____ 3 months	NO refills

Prescriber Information

Date prescription needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____ Tax ID #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____

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:** _____