



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 T-Z
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
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg/1mL Autoinjector 00002-1445-11 (1 pack)	PLAQUE PSORIASIS: <input type="checkbox"/> INDUCTION DOSE: 160 mg subcutaneously at week 0, followed by 80 mg subcutaneously at weeks 2, 4, 6, 8, 10, and 12. <input type="checkbox"/> MAINTENANCE DOSE: 80 mg subcutaneously every 4 weeks.	#8	NO refills
		<input type="checkbox"/> 80 mg/1mL Autoinjector 00002-1445-27 (2 pack)	#1	_____
	<input type="checkbox"/> 80 mg/1mL Prefilled Syringe 00002-7724-11 (1 pack)	PSORIATIC ARTHRITIS: <input type="checkbox"/> INDUCTION DOSE: 160 mg subcutaneously at week 0, followed by 80 mg subcutaneously every 4 weeks. <input type="checkbox"/> MAINTENANCE DOSE: 80 mg subcutaneously every 4 weeks.	#2	NO refills
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg <input type="checkbox"/> 11mg	<input type="checkbox"/> Take 1 tablet by mouth twice daily <input type="checkbox"/> Take 1 tablet by mouth once daily	60 3 months	_____ _____

**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:** _____