



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 A-E
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

MEDICATIONS	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Actemra®	<input type="checkbox"/> 162 mg/0.9 mL PFS <input type="checkbox"/> Vials	<input type="checkbox"/> 162 mg Sub-Q every other week <input type="checkbox"/> 162 mg Sub-Q once a week <input type="checkbox"/> IV: Infuse _____ mg via IV every 4 weeks	<input type="checkbox"/> 2 PFS <input type="checkbox"/> 4 PFS <input type="checkbox"/> _____	
<input type="checkbox"/> Cimzia®	Starter Dose <input type="checkbox"/> 200mg/ml Prefilled Syringe Starter Kit NDC: 50474-0710-81 <input type="checkbox"/> 200mg Lyophilized Powder (LYO)	Initial dose of 400mg SC at weeks 0, 2, and 4 <input type="checkbox"/> 400mg SC every 4 weeks <input type="checkbox"/> 200mg SC every 2 weeks	1 Kit	0
	Maintenance Dose <input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg Lyophilized Powder (LYO)		3 Kits	0
<input type="checkbox"/> Cosentyx®	Starter Dose <input type="checkbox"/> 150mg/mL Sensoready® Pen <input type="checkbox"/> 150mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3 <input type="checkbox"/> Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	#4	
	Maintenance Dose <input type="checkbox"/> 150mg/mL Sensoready® Pen <input type="checkbox"/> 150mg/mL Prefilled Syringe		#8	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml Sureclick™ Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe (PFS) <input type="checkbox"/> 25mg Vial (inj. supplies incl) <input type="checkbox"/> 50mg/mL mini pre-filled cartridge	<input type="checkbox"/> Inject 50mg SC ONCE a week <input type="checkbox"/> _____ <input type="checkbox"/> Inject 25mg SC TWICE a week	4-weeks	_____
			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:** _____