Giant Eagle Specialty Pharmacy

Phone: 1-888-792-1552
Fax: 1-888-216-2510

To ePrescribe send prescription to:
Giant Eagle Pharmacy
20160 Center Ridge Road, Suite 201
Rocky River, OH 44116

HUMIRA 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: _____
Best E-mail Address: _____
Height: _____Weight: _____ ☐ kgs. or ☐ lbs. Recorded Date: _____
Caregiver: _____ Allergies: _____
Store Preference (address): _____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

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

Rx

PATIENTS NEW TO THERAPY
☐ **Humira® Crohn's or Ulcerative Colitis STARTER PACK** (NDC #0074-0124-03): 160mg Day 1, 80mg Day 15 then **MAINTENANCE DOSE** (NDC #0074-0554-02): 40mg Day 29 & every other week thereafter
MAINTENANCE REFILLS #: _____

RENEWALS/OTHER
☐ Humira 40mg **Pen** every other week, Maintenance Dose (NDC #0074-0554-02) **Days Supply #:** _____ **Refills #:** _____
☐ Humira 40mg **Syringe** every other week, Maintenance Dose (NDC #0074-0243-02) **Days Supply #:** _____ **Refills #:** _____

Medical Assessment

Diagnosis Crohn's Disease
☐ ICD-10 Code _____ ☐ Other: _____
PATIENT HAS A NEGATIVE TB TEST RESULT
Date of Test: _____
Indication: Please CHECK the appropriate box(es) related to the patient's condition:
☐ Failure to Remicade Infusions Trial Dates: _____
☐ Crohn's Disease Patient has moderate to severe Crohn's disease and is exhibiting inadequate response to conventional therapy (write in box on right)
Drug Allergies: _____
_____
_____

Prior (FAILED) Medications:

	Medications	Date
Corticosteroids		
Methotrexate		
Azathioprine/6MP		
Sulfasalazine/Mesalamine		
Other Biologics		
Cyclosporine		
Other		

Additional Justification for Drug: _____

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____ Tax ID #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____ DEA #: _____

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:** _____