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

MULTIPLE SCLEROSIS 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: _____ 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)

Prescription Information

ICD-10 Code: _____ Date of first demyelinating event: _____
Type: ☐ Relapsing-remitting ☐ Secondary progressive with relapses ☐ Primary progressive
☐ Secondary progressive without relapses ☐ Clinically Isolated Syndrome (CIS) ☐ Progressive relapsing
Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):
Prior therapies: _____ Reason for discontinuation: _____ Other: _____

Date Shipment Needed: _____ **Ship to:** ☐ **Patient** ☐ **Physician/Clinic**

Drug Name	Strength	SIG/Directions	Other SIG	Quantity	# of Refills
☐ **Copaxone**	20mg	Inject 20mg SQ Daily		1 kit=30 prefilled syringes	
☐ **Copaxone**	40mg	Inject 40mg SQ 3x weekly		1 kit=12 prefilled syringes	
☐ **Glatiramer acetate**	20mg	Inject 20mg SQ daily		1 kit=30 prefilled syringes	
☐ **Glatiramer acetate**	40mg	Inject 40mg SQ 3 X weekly		1 kit=12 prefilled syringes	
☐ **Glatopa**	20mg	Inject 20mg SQ Daily		1 kit=30 prefilled syringes	
☐ **Autoject** 2 for glass syringe injection device/PRN (to be provided by Shared Solutions)					
☐ **Enroll in Shared Solutions/Needs Nurse Training/800-887-8100**					
☐ **Avonex PFS**	30mcg	Inject 30mcg IM once weekly		1 kit=4 prefilled syringes	
☐ **Avonex Pen**	30mcg	Inject 30mcg IM once weekly		1 pack=4 pens or 3 packs=12 pens	
☐ **Enroll in MS ActiveSource/Needs Nurse Training/800-456-2255**					
☐ **Extavia** (interferon beta-1b)	0.25mg	0.25 mg injected SC every other day		15 blister units per package	
☐ **Gilenya capsules** (fingolimod)	0.5mg	Taken orally once daily		Carton of 28 or carton of 7	
☐ **Betaseron**	0.3mg	☐ Sig. Titration Per Package Insert Weeks 1-2: 0.0625mg/0.25ml SQ QOD Weeks 3-4: 0.125mg/0.50ml SQ QOD Weeks 5-6: 0.1875mg/0.75ml SQ QOD Weeks 7+: 0.25mg/1ml SQ QOD	☐ No Titration Dose: 0.25mg (1ml) SQ QOD ☐ Other Sig: _____	1 kit=15 prefilled syringes	
☐ **BETAJECT Lite Autoinjector** (to be provided by BETAPLUS)					
☐ **Enroll in BETAPLUS/Needs Nurse Training/800-977-2770**					
☐ **Rebif Titration Pack**	8.8mcg (0.2ml) 22mcg (0.5ml)	Inject 8.8mcg (0.2ml) SQ 3x weekly for weeks 1-2 and 22mcg (0.5ml) SQ 3x weekly for weeks 3-4		1 kit=6x8.8mcg syringes and 6x22mcg syringes	
☐ **Rebif**	22mcg/0.5ml	Inject 8.8mcg (0.2ml) SQ 3x weekly for weeks 1-2 and 22mcg (0.5ml) SQ 3x weekly for week 3-4			
☐ **Rebif**	44mcg/0.5ml	Inject 44mcg (0.5ml) SQ 3x weekly			
☐ **Rebiject II Autoinjector/Travel Kit** (to be provided by MS LifeLines)/**877-447-3243**					

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #: _____ NPI #: _____
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:** _____