meijer specialty pharmacy

P: 1-855-263-4537 • F: 734-391-2365
www.meijerspecialtypharmacy.com

Dermatology (P-Z)

Siliq®, Simponi®, Stelara®, Taltz®, Tremfya®

Send updates to: ◯ Fax: _____ ◯ Email: _____

Physician Information

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:	Practice Name / Supervising MD:		
Address:	City:		
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	◯ Psoriasis Vulgaris (L40.0)	◯ Other Psoriasis (L40.8)	◯ Psoriasis unspecified (L40.9)	◯ Psoriatic Arthritis (L40.5)	◯ Hidradenitis Suppurativa (L73.2)	◯ Chronic Urticaria (L50.8)
◯ Atopic Dermatitis (L20.9)	TB/PDD Test Given? ◯ Y ◯ N	Date of Neg. Test: / /	HBV Positive? ◯ Y ◯ N	If yes, patient currently treated? ◯ Y ◯ N		
Prior Treatment? ◯ Y ◯ N (Provide Information Below)	BSA affected (%):	Affected Areas: ◯ Palms ◯ Soles ◯ Head ◯ Neck ◯ Genitalia ◯ Other:				

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
Comorbidities:	Concomitant Medications:	Allergies: ◯ NKDA ◯ Other:	

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **SILIQ®** ◯ PFS *Product is limited to certified prescribers enrolled in Siliq REMS	◯ 2 cartons (4x210mg/1.5mL)	◯ **Starter Dose:** Inject 210 mg SQ at weeks 0, 1, and 2 and then every 2 weeks thereafter	No Refills
	◯ 1 carton (2x210mg/1.5mL)	◯ **Maintenance Dose:** Inject 210 mg SQ once every 2 weeks	
◯ **SIMPONI®** ◯ SmartJect® ◯ PFS	◯ 1 carton (1x50mg/0.5ml)	◯ Inject 50 mg SQ once a month	
◯ **STELARA®** ◯ PFS Patient eligible for self-injection? ◯ Yes ◯ No	◯ 1 carton (1x45mg/0.5mL) ◯ 1 carton (1x90mg/mL)	◯ **Starter Dose:** Inject 45 mg SQ on Day 1 (≤100 kg) ◯ **Starter Dose:** Inject 90 mg SQ on Day 1 (>100 kg)	No Refills
		◯ **Maintenance Dose:** Inject 45mg SQ once every 12 weeks beginning on Day 29 (≤100kg) ◯ **Maintenance Dose:** Inject 90mg SQ once every 12 weeks beginning on Day 29 (>100kg)	
◯ **TALTZ®** *Plaque Psoriasis* ◯ Autoinjector ◯ PFS	◯ 3x80mg/ml	◯ **Starter Dose:** Inject 160mg SQ on Day 0 and 80mg SQ at week 2	No Refills
	◯ 2x80mg/ml	◯ **Titration Dose:** Inject 80mg SQ at weeks 4, 6, 8, 10	1 Refill
	◯ 1x80mg/ml	◯ **Maintenance Dose:** Inject 80mg SQ every 4 weeks starting at week 12	8 Refills
◯ **TALTZ®** *Psoriatic Arthritis* ◯ Autoinjector ◯ PFS	◯ 2x80mg/ml	◯ **Starter Dose:** Inject 160mg SQ on Day 0	No Refills
	◯ 1x80mg/ml	◯ **Maintenance Dose:** Inject 80mg SQ every 4 weeks starting at week 4	10 Refills
◯ **TREMFYA®** ◯ PFS	◯ 2 cartons (2x100mg/mL)	◯ **Starter Dose:** Inject 100 mg SQ at weeks 0 and 4	No Refills
	◯ 1 carton (1x100mg/mL)	◯ **Maintenance Dose:** Inject 100 mg SQ every 8 weeks	
◯ Other:			

Injection Training

◯ Patient received injection training	◯ Prescriber's office to provide injection training	◯ Meijer to coordinate injection training	◯ Patient to receive injection training at Meijer

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: Date	Physician Signature: Date
Substitution Permitted	Dispense as Written