meijer specialty pharmacy

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

Gastroenterology

Physician Information

Send updates to: ◯ Fax: ______________________ ◯Email: ______________________

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: **Crohn's Disease:** ◯K50.0___(Crohn's of the **Small** Intestine) ◯ K50.1___(Crohn's of the **Large** Intestine) ◯ K50.8___(Crohn's of **Both** Intestines) ◯ K50.9___(Crohn's, Unspecified)

Ulcerative Colitis: ◯K51.0___(Ulcerative Pancolitis) ◯ K51.2___(Ulcerative Procolitis) ◯ K51.3___(Ulcerative Rectosigmoiditis) ◯ K51.5___(Left Sided Colitis) ◯ K51.8___(Other Ulcerative Colitis)

◯ K51.9___ (Ulcerative Colitis, Unspecified) ◯ K58.0___ (Irritable Bowel Syndrome with Diarrhea) ◯ Other:

Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? ◯ Yes ◯ No (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy

Prescription Information

Medication	Quantity/Strength	Sig	Refills
◯ **CIMZIA**® ◯PFS ◯ Vials	◯ Prefilled Syringe Starter Kit (6x200mg/ml) ◯ 1 carton (2x200mg/ml)	◯ **Starter Dose:** Inject 400mg SQ at weeks 0, 2, and 4 ◯ **Maintenance Dose:** Inject 400mg SQ every 4 weeks ◯ **Maintenance Dose:** Inject 200mg SQ every 2 weeks	
◯ **HUMIRA**® ◯ Pen ◯ PFS	**Pens Only:** ◯ Starter Kit (6x40mg/0.8ml) ◯ Citrate Free Starter Kit (3x80mg/0.8ml)	◯ **Starter Dose:** Inject 160mg SQ on day 1, then 80mg on day 15, then begin maintenance dosing on day 29	
	◯ 1 carton (2x40mg/0.8ml) ◯ Citrate Free 1 carton (2x40mg/0.4ml)	◯ **Maintenance Dose:** Inject 40mg SQ every 14 days	
◯ **SIMPONI**® ◯ SmartJect ◯ PFS	◯ 1 carton (1x50mg/0.5ml PFS) ◯ 1 carton (1x100mg/ml PFS) ◯ 1 carton (1x50mg/0.5ml Autoinjector) ◯ 1 carton (1x100mg/ml Autoinjector)	◯ **Starter Dose:** Inject 200 mg SQ at week 0; then 100 mg at week 2 ◯ **Maintenance Dose:** Inject 100mg SQ every 4 weeks, starting at week 6	
◯ **STELARA**®	◯ 1 carton (1x45mg/0.5ml PFS) ◯ 1 carton (1x90mg/ml PFS)	**Maintenance Dose:** ◯ Inject 0.5ml (45mg) SQ 8 weeks after infusion, then every 8 weeks thereafter ◯ Inject 1ml (90mg) SQ 8 weeks after infusion, then every 8 weeks thereafter	
◯ **XELJANZ**®	◯ 10mg tablets (Number of tablets: ______)	◯ **Starter Dose:** Take 10mg by mouth twice daily for _____ weeks	No Refills
	◯ 5mg tablets (30 day supply) ◯ 10mg tablets (30 day supply)	◯ **Maintenance Dose:** Take 1 tablet by mouth two times a day	
◯ **XIFAXAN**®	◯ 200mg tablet ◯ 550mg tablet	◯ Take 1 tablet by mouth 2 times a day for _______ days ◯ Take 1 tablet by mouth 3 times a day for _______ days	
◯ Other			

Injection Training

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

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