

Ship Meds to: Patient's Home Prescriber's Office

Prescriber Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:
Office Contact:		Practice name/Collaborating Physician:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

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

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

Diagnosis: M32.9 Active Systemic Lupus Erythematosus M32.14 Glomerular disease in systemic lupus erythematosus Other

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

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
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Comorbidities: _____ Concomitant Medications: _____

Allergies: NKDA Other: _____

Start Date: / /

Prescription Information

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> BENLYSTA® *SLE <input type="radio"/> PFS <input type="radio"/> Pen	<input type="radio"/> 1 carton (4x200mg/ml autoinjector) <input type="radio"/> 1 carton (4x200mg/ml PFS)	<input type="radio"/> Maintenance Dose: Administer 200mg SQ once every week	
<input type="radio"/> BENLYSTA® *Lupus nephritis <input type="radio"/> PFS <input type="radio"/> Pen	<input type="radio"/> 1 carton (4x200mg/ml autoinjector) <input type="radio"/> 1 carton (4x200mg/ml PFS)	<input type="radio"/> Starter Dose: Inject 400mg (two 200mg injections) SQ once weekly for 4 doses	No Refills
	<input type="radio"/> 1 carton (4x200mg/ml) autoinjector <input type="radio"/> 1 carton (4x200mg/ml) PFS	<input type="radio"/> Maintenance Dose: Inject 200mg SQ once every week	
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.

Prescriber Signature: _____ Date _____

Prescriber Signature: _____ Date _____

Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.