

Send updates to:  Fax: \_\_\_\_\_  Email: \_\_\_\_\_

**Physician Information**

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> 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: <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  M45.9 Ankylosing Spondylitis  M08.0 Juvenile Idiopathic Arthritis  L40.59 Psoriatic Arthritis  
 L40.54 Psoriatic Juvenile Arthritis  M06.9 Rheumatoid Arthritis  H20 Iridocyclitis (Uveitis)  Other:

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

Prior Therapy	Reason for Discontinuation of Therapy	Approx. Start Date	Approx. End Date
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Comorbidities: \_\_\_\_\_ Concomitant Medications: \_\_\_\_\_

Allergies:  NKDA  Other:

**TREATMENT ARRANGEMENTS:** Ship Meds:  Home  Doctor's Office Start Date: / /

**Prescription Information**

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> <b>ACTEMRA®</b> <input type="radio"/> PFS	<input type="radio"/> 2 cartons (2x162mg/0.9ml) <input type="radio"/> 4 cartons (4x162mg/0.9ml)	<input type="radio"/> Inject 162 mg SQ every other week (<100kg) <input type="radio"/> Inject 162 mg SQ every week (>100kg)	
<input type="radio"/> <b>BENLYSTA®</b> <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"/> <b>Maintenance Dose:</b> Administer 200mg SQ once every week	
<input type="radio"/> <b>CIMZIA®</b> <input type="radio"/> PFS <input type="radio"/> Vial	<input type="radio"/> <b>PFS Only:</b> Starter Kit (6x200mg/ml)	<input type="radio"/> <b>Starter Dose:</b> Inject 400 mg SQ at weeks 0, 2, and 4	No Refills
	<input type="radio"/> 1 carton (2x200 mg/ml)	<input type="radio"/> <b>Maintenance Dose:</b> Inject 400 mg SQ every 4 weeks <input type="radio"/> <b>Maintenance Dose:</b> Inject 200 mg SQ every 2 weeks	
<input type="radio"/> <b>COSENTYX®</b> <input type="radio"/> PFS <input type="radio"/> Sensoready® Pen	<input type="radio"/> 4 cartons (8x150mg/ml) <input type="radio"/> 4 cartons (4x150mg/ml)	<input type="radio"/> <b>Starter Dose:</b> Inject 300 mg SQ at weeks 0, 1, 2, 3 <input type="radio"/> <b>Starter Dose:</b> Inject 150 mg SQ at weeks 0, 1, 2, 3	No Refills
	<input type="radio"/> 1 carton (2x150mg/ml) <input type="radio"/> 1 carton (1x150mg/ml)	<input type="radio"/> <b>Maintenance Dose:</b> Inject 300 mg SQ every 4 weeks beginning on Day 29 <input type="radio"/> <b>Maintenance Dose:</b> Inject 150 mg SQ every 4 weeks beginning on Day 29	
<input type="radio"/> <b>ENBREL®</b> <input type="radio"/> Mini <input type="radio"/> PFS <input type="radio"/> SureClick <input type="radio"/> Vial	<input type="radio"/> 1 carton (4 x 50mg/ml)	<input type="radio"/> Inject 50 mg SQ every week	
	<input type="radio"/> Other:	<input type="radio"/> Other Regimen:	
<input type="radio"/> <b>HUMIRA®</b> <input type="radio"/> PFS <input type="radio"/> Pen	<input type="radio"/> 1 carton (2x40mg/0.8ml) <input type="radio"/> 2 cartons (4x40mg/0.8ml) <input type="radio"/> Citrate Free: 1 carton (2x40mg/0.4ml) <input type="radio"/> Citrate Free: 2 cartons (4x40mg/0.4ml)	<input type="radio"/> Inject 40 mg SQ every 14 days <input type="radio"/> Inject 40 mg SQ every 7 days	
	<input type="radio"/> 1 carton (2x10mg/0.1mL PFS) <input type="radio"/> 1 carton (2x20mg/0.2mL PFS) <input type="radio"/> 1 carton (40mg/0.4mL PFS) <input type="radio"/> 1 carton (40mg/0.4mL PEN)	<input type="radio"/> <b>Weight 10-14kg:</b> Inject 10mg SQ every other week <input type="radio"/> <b>Weight 15-29kg:</b> Inject 20mg SQ every other week <input type="radio"/> <b>Weight ≥30kg:</b> Inject 40mg SQ every other week	
	<input type="radio"/> <b>Pens Only:</b> <input type="radio"/> Starter Kit (4x40mg/0.8ml) <input type="radio"/> Citrate Free Starter Kit (1x80mg/0.8ml, 2x40mg/0.4ml)	<input type="radio"/> Inject 80mg SQ on Day 1, then 40mg on day 8, then 40mg every 2 weeks	No Refills
	<input type="radio"/> 1 carton (2x40mg/0.8 ml) <input type="radio"/> Citrate Free 1 carton (2x40mg/0.4ml)	<input type="radio"/> Inject 40mg SQ every 14 days	
<input type="radio"/> <b>KEVZARA®</b> <input type="radio"/> PFS <input type="radio"/> Pen	<input type="radio"/> 1 carton (2x200mg/1.14ml) <input type="radio"/> 1 carton (2x150mg/1.14ml)	<input type="radio"/> Inject 200mg SQ every 2 weeks <input type="radio"/> Inject 150mg SQ every 2 weeks	

**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 _____
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Substitution Permitted

Dispense as Written