

Prescriber Information											
Prescriber Name:					MD	DO	NP	PA	NPI:		
Office Contact:					Practice Name / Collaborating MD:						
Address:				City:			State:		Zip:		
Phone:			Fax:								
Patient Information • PLEASE SEND COPY OF INSURANCE CARD											
Patients Name:			Last 4 Digits of SS#:		DOB: / /		Sex: M F		Weight:	Height:	Diabetic? Y N
Office Contact:					Practice Name / Collaborating MD:						
Address:				City:			State:		Zip:		
Home Phone:			Work/Cell:		HIPPA Contact:			Emergency #:			
Interpreter Needed? Y N		Allergies: Y N If Yes, list allergies:									
Insurance Information											
Primary Insurance:			Policy ID:		Group #:		BIN:		PCN:		
Policyholder Name:					Policyholder DOB: / /						
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: / /			Prior Treatment? Y N (Provide Information Below)				
Prior Therapy:				Reason for Discontinuation of Therapy:				Approx. Start Date: / /			
								Approx. End Date: / /			
Prescription Information											
Medication		Quantity/Dose			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						
DUPIXENT® Pen PFS		2 cartons (4x300mg/2ml)			Inject 300mg SQ once weekly						
HUMIRA® Pen PFS		Pens Only: Citrate Free Starter Kit (3x80mg/0.8ml) Citrate Free 1 carton (2x40mg/0.4ml)			Starter Dose (children ≥ 40kg and adults): Inject 160mg SQ on day 1, then 80mg on day 15, then begin maintenance dosing on day 29 Inject 80mg SQ on days 1 and 2, then 80mg on day 15, then begin maintenance dosing on day 29 Maintenance Dose: Inject 40mg SQ every 14 days			No Refills			
HUMIRA® <i>*Pediatric Crohn's Disease</i>		Starter Kit: 1 carton (3x80mg/0.8mL PFS) 1 carton (1x80mg/0.8mL + 1x40mg/0.4ml PFS)			Starter Dose: Weight 15-29kg: Inject 80mg SQ on day 1, then 40mg on day 15, then begin maintenance dosing on day 29 Starter Dose: Weight ≥ 40kg: Inject 160mg on day 1, then 80mg on day 15, then begin maintenance dosing on day 29 Inject 80mg SQ on days 1 and 2, then 80mg on day 15, then begin maintenance dosing on day 2			No Refills			
		1 carton (2x20mg/0.2mL PFS) 1 carton (2x40mg/0.4mL PFS) 1 carton (2x40mg/0.4mL PEN)			Maintenance Dose: Inject 20mg SQ every 14 days Inject 40mg SQ every 14 days						
HUMIRA® <i>*Pediatric Ulcerative Colitis</i>		Starter Dose: Weight 15-29kg: 2 cartons (4X40mg/0.4ml PEN)			Starter Dose: Weight 15-29kg: Inject 80mg SQ on day 1, then 40mg on day 8, then 40mg on day 15. Begin maintenance dosing on day 29			No Refills			
		Starter Kit: Weight ≥ 40kg 1 carton (4x80mg/0.8ml) PEN			Weight ≥40kg Inject 160mg SQ on day 1, then 80mg on day 8, then 80mg on day 15. Begin maintenance dosing on day 29. Inject 80mg SQ on days 1 and 2, then 80mg on day 8, then 80mg on day 15. Begin maintenance dosing on day 29.			No Refills			
		2 cartons (4x20mg/0.2mL PFS) 1 carton (2x40mg/0.4mL PFS) 1 carton (2x40mg/0.4mL PEN) 2 cartons (4x40mg/0.4mL PFS) 2 cartons (4x40mg/0.4mL PEN) 1 carton (2x80mg/0.8mL PEN)			Maintenance Dose: Weight 20-39kg: Inject 40mg SQ every other week Inject 20mg SQ every week Maintenance Dose: Weight ≥40kg: Inject 80mg SQ every other week Inject 20mg SQ every week						
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.