

Send updates to: Fax: _____ Email: _____

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/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		
Primary Insurance:	Policy ID:	Group #:				
Policyholder Name:	Policyholder DOB:	BIN:	PCN:			
Prior Therapy:	Reason for Discontinuation of Therapy:					
Comorbidities:	Concomitant Medications:					

Dermatology | 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:	<input type="radio"/> Psoriasis Vulgaris (L40.0) <input type="radio"/> Other Psoriasis (L40.8) <input type="radio"/> Psoriasis unspecified (L40.9) <input type="radio"/> Psoriatic Arthritis (L40.5) <input type="radio"/> Hidradenitis Suppurativa (L73.2) <input type="radio"/> Chronic Urticaria (L50.8)					
<input type="radio"/> Atopic Dermatitis (L20.9)	TB/PDD Test Given? <input type="radio"/> Y <input type="radio"/> N	Date of Neg. Test: / /	HBV Positive? <input type="radio"/> Y <input type="radio"/> N	If yes, patient currently treated? <input type="radio"/> Y <input type="radio"/> N		
Prior Treatment? <input type="radio"/> Y <input type="radio"/> N (Provide Information Below)	BSA affected (%):	Affected Areas: <input type="radio"/> Palms <input type="radio"/> Soles <input type="radio"/> Head <input type="radio"/> Neck <input type="radio"/> Genitalia <input type="radio"/> Other:				
Allergies: <input type="radio"/> NKDA <input type="radio"/> Other:	Approximate Start Date		Approximate End Date			

Gastroenterology | 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: <input type="radio"/> K50.0 (Crohn's of the Small Intestine) <input type="radio"/> K50.1 (Crohn's of the Large Intestine) <input type="radio"/> K50.8 (Crohn's of Both Intestines) <input type="radio"/> K50.9 (Crohn's, Unspecified)					
Ulcerative Colitis:	<input type="radio"/> K51.0 (Ulcerative Pancolitis) <input type="radio"/> K51.2 (Ulcerative Procolitis) <input type="radio"/> K51.3 (Ulcerative Rectosigmoiditis) <input type="radio"/> K51.5 (Left Sided Colitis) <input type="radio"/> K51.8 (Other Ulcerative Colitis)					
<input type="radio"/> K51.9 (Ulcerative Colitis, Unspecified) <input type="radio"/> K58.0 (Irritable Bowel Syndrome with Diarrhea) <input type="radio"/> Other:						
Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? <input type="radio"/> Yes <input type="radio"/> No (provide information below)				

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

Diagnosis:	<input type="radio"/> M32.9 Active Systemic Lupus Erythematosus <input type="radio"/> M45.9 Ankylosing Spondylitis <input type="radio"/> M08.0 Juvenile Idiopathic Arthritis <input type="radio"/> L40.59 Psoriatic Arthritis <input type="radio"/> L40.54 Psoriatic Juvenile Arthritis					
<input type="radio"/> M06.9 Rheumatoid Arthritis <input type="radio"/> H20 Iridocyclitis (Uveitis) <input type="radio"/> Other:						
Date of Diagnosis: / /		Date of Negative TB Test: / /				
Any prior treatment? <input type="radio"/> Yes <input type="radio"/> No (provide information below)	Allergies: <input type="radio"/> NKDA <input type="radio"/> Other:	Approx. Start Date		Approx. End Date		

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

Prescription Information

Medication	Dose/Strength	Sig	Refills
<input type="radio"/> BENLYSTA®	<input type="radio"/> Number of 120mg/5ml vials: _____ <input type="radio"/> Number of 400mg/20ml vials: _____	<input type="radio"/> Starter Dose: Infuse _____mg IV over 1 hour at weeks 0, 2, and 4 <input type="radio"/> Maintenance Dose: Infuse _____mg IV over 1 hour once every 4 weeks	No Refills
<input type="radio"/> ENTYVIO®	<input type="radio"/> Starter dose: 2 vials <input type="radio"/> Maintenance dose: Number of 300mg vials: _____	<input type="radio"/> Starter dose: Infuse 300mg IV over 30 minutes at weeks 0 and 2 <input type="radio"/> Maintenance dose: Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6	No Refills
<input type="radio"/> KRSTEXXA®	<input type="radio"/> Number of 8mg/ml vials: _____	<input type="radio"/> Infuse 8mg IV over 2 hours every 2 weeks	
<input type="radio"/> ORENCIA®	<input type="radio"/> Number of 250mg vials: _____	<input type="radio"/> Starter Dose: Infuse _____mg IV in 100ml NS over 30 minutes at weeks 0 and 2 <input type="radio"/> Maintenance Dose: Infuse _____mg IV in 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter	No Refills
<input type="radio"/> REMICADE®	<input type="radio"/> Number of 100mg vials: _____	<input type="radio"/> Starter Dose: Infuse _____mg IV over 2 hours at weeks 0, 2 and 6 <input type="radio"/> Maintenance Dose: Infuse _____mg IV over 2 hours once every _____ weeks	No Refills
<input type="radio"/> RITUXAN®	<input type="radio"/> Number of 100mg/10ml vials: _____ <input type="radio"/> Number of 500mg/50ml vials: _____	<input type="radio"/> Starter dose: Infuse 1000mg IV over 4-6 hours on day 1 and day 15 <input type="radio"/> Maintenance dose: Infuse 1000mg IV over 4-6 hours every _____ weeks	No Refills
<input type="radio"/> SIMPONI ARIA®	<input type="radio"/> Number of 50mg/4ml vials: _____	<input type="radio"/> Starter Dose: Infuse _____mg IV over 30 minutes at weeks 0 and 4 <input type="radio"/> Maintenance Dose: Infuse _____mg IV over 30 minutes once every 8 weeks	No Refills
<input type="radio"/> STELARA®	<input type="radio"/> Number of 45mg/0.5ml vials: _____ <input type="radio"/> Number of 130mg/26ml vials: _____	Starter Dose: <input type="radio"/> Weight > 85kg: Infuse 520mg IV over 1 hour <input type="radio"/> Weight 56kg – 85kg: Infuse 390mg IV over 1 hour <input type="radio"/> Weight ≤ 55kg: Infuse 260mg IV over 1 hour Begin the SQ maintenance regimen 8 weeks after the initial IV dose	No Refills

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
-----------------------	------	-----------------------	------