

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		

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 Code:	Weight _____ <input type="radio"/> lb / <input type="radio"/> kg	Height _____ <input type="radio"/> in / <input type="radio"/> cm	BSA _____ m ²	Diagnosis Date: / /
Current SCR _____ or current GFR _____ ml/min	Confirmed Mutations:			
Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date	

Prescription Information

Medication	Dose/Strength	Sig (Please Include Cycle)	Quantity	Refills
<input type="radio"/> ABRAXANE® (paclitaxel protein-bound)	<input type="radio"/> 100mg vial			
<input type="radio"/> ADCETRIS® (brentuximab vedotin)	<input type="radio"/> 50mg vial			
<input type="radio"/> ALIMTA® (pemetrexed)	<input type="radio"/> 100mg vial <input type="radio"/> 500mg vial			
<input type="radio"/> ARZERRA® (ofatumumab)	<input type="radio"/> 100mg/5mL vial <input type="radio"/> 1000mg/50mL vial			
<input type="radio"/> AVASTIN® (bevacizumab) Biosimilars: <input type="radio"/> Mvasi™ <input type="radio"/> Zirabev®	<input type="radio"/> 100mg vial <input type="radio"/> 400mg vial			
<input type="radio"/> CLOLAR® (clofarabine)	<input type="radio"/> 20mg vial			
<input type="radio"/> CYCLOPHOSPHAMIDE	<input type="radio"/> 500mg vial <input type="radio"/> 1g vial <input type="radio"/> 2g vial			
<input type="radio"/> EMPLICITI® (elotuzumab)	<input type="radio"/> 300mg vial <input type="radio"/> 400mg vial			
<input type="radio"/> ERBITUX® (cetuximab)	<input type="radio"/> 100mg/50mL vial <input type="radio"/> 200mg/100mL vial			
<input type="radio"/> HALAVEN® (eribulin mesylate)	<input type="radio"/> 1mg/2mL vial			
<input type="radio"/> HERCEPTIN® (trastuzumab) Biosimilars: <input type="radio"/> Herzuma® <input type="radio"/> Ontruzant® <input type="radio"/> Kanjinti™ <input type="radio"/> Trazimera™ <input type="radio"/> Ogivri™	<input type="radio"/> 150mg vial <input type="radio"/> 420mg vial (biosimilars only)			

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
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Substitution Permitted

Dispense as Written

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