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Dermatology (A-D)

Cimzia®, Cosentyx®, Dupixent™

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: Psoriasis Vulgaris (L40.0) Other Psoriasis (L40.8) Psoriasis unspecified (L40.9) Psoriatic Arthritis (L40.5) Hidradenitis Suppurativa (L73.2) Chronic Urticaria (L50.8)

Atopic Dermatitis (L20.9) Basal cell carcinoma (C44.____) | TB/PDD Test Given: Y N | Date of Neg. Test: / / | HBV Positive? Y N **If Yes, is patent currently treated?** Y N

Prior Treatment? Y N **(Provide Information Below)** | BSA Affected (%): | Affected Areas: Palms Soles Head Neck Genitalia Other:

Prior Therapy: | Reason for Discontinuation of Therapy: | Approx. Start Date: / / | Approx. End Date: / /

Comorbidities: | Concomitant Medications: | Allergies: NKDA Other:

Prescription Information

Medication	Quantity/Dose	Sig	Refills
CIMZIA® PFS Vials	1 starter kit (6x200mg/mL)	**Starter Dose:** Inject 400mg SQ at weeks 0, 2 and 4	**No Refills**
	1 carton (2x200mg/mL) 2 cartons (4x200mg/mL)	**Maintenance Dose:** Inject 400mg SQ every 4 weeks Inject 200mg SQ every 2 weeks Inject 400mg SQ every other week *(plaque psoriasis only)* Inject 200mg SQ every other week	
COSENTYX® **Pediatrics (age 6 & older)*	4 cartons (4x75mg/0.5ml) PFS 4 cartons (4x150mg/ml) PFS 4 cartons (4x150mg/ml) PEN	**Starter Dose:** **Weight < 50kg:** Inject 75mg SQ at weeks 0, 1, 2, and 3 **Weight ≥ 50kg:** Inject 150mg SQ at weeks 0, 1, 2, and 3	**No Refills**
	1 carton (1x75mg/0.5ml) PFS 1 carton (1x150mg/ml) PFS 1 carton (1x150mg/ml) PEN	**Maintenance Dose:** **Weight < 50kg:** Inject 75mg SQ every 4 weeks beginning on Day 29 **Weight ≥ 50kg:** Inject 150mg SQ every 4 weeks beginning on Day 29	
COSENTYX® **Adults* PFS Sensoready® Pen	4 cartons (8x150mg/mL) 4 cartons (4x150mg/mL)	**Starter Dose:** Inject 300 mg SQ at weeks 0, 1, 2, and 3 **Starter Dose:** Inject 150 mg SQ at weeks 0, 1, 2, and 3	**No Refills**
	1 carton (2x150mg/mL) 1 carton (1x150mg/mL)	**Maintenance Dose:** Inject 300 mg SQ every 4 weeks beginning on Day 29 **Maintenance Dose:** Inject 150 mg SQ every 4 weeks beginning on Day 29	
DUPIXENT® **Pediatrics (age 6 & older)*	1 carton (2x200mg/1.14mL) PFS 1 carton (2x300mg/2mL) PFS 1 carton (2x300mg/2mL) PEN ***Dupixent pens only for use in adolescents aged 12 or older**	**Starter Dose:** **Weight 15-29kg:** Inject 600mg SQ at week 0. Begin maintenance dose at week 4 **Weight 30-59kg:** Inject 400mg SQ at week 0. Begin maintenance dose at week 2 **Weight ≥ 60kg:** Inject 600mg SQ at week 0. Begin maintenance dose at week 2	**No Refills**
	1 carton (2x200mg/1.14mL) PFS 1 carton (2x300mg/2mL) PFS 1 carton (2x300mg/2mL) PEN ***Dupixent pens only for use in adolescents aged 12 or older**	**Maintenance Dose:** **Weight 15-29kg:** Inject 300mg SQ every 4 weeks **Weight 30-59kg:** Inject 200mg SQ every 2 weeks **Weight ≥ 60kg:** Inject 300mg SQ every 2 weeks	
DUPIXENT® **Adults*	1 carton (2x300mg/2mL) PFS 1 carton (2x300mg/2mL) PEN	**Starter Dose:** Inject 600mg SQ at week 0. Begin maintenance dose at week 2	**No Refills**
	1 carton (2x300mg/2mL) PFS 1 carton (2x300mg/2mL) PEN	**Maintenance Dose:** Inject 300mg 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.

Prescriber Signature	Date	Prescriber Signature	Date

Substitution Permitted | Dispense as Written

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