

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
SILIQ® <small>*Product is limited to certified prescribers enrolled in Siliq REMS</small>	2 cartons (4x210mg/1.5mL)	Starter Dose: Inject 210 mg SQ at weeks 0, 1, and 2 and then every 2 weeks after	No Refills
	1 carton (2x210mg/1.5mL)	Maintenance Dose: Inject 210 mg SQ once every 2 weeks	
SIMPONI® SmartLect® PFS	1 carton (1x50mg/0.5ml)	Inject 50 mg SQ once a month	
SKYRIZI™ PFS Pen	1 carton (150mg/mL)	Starter Dose: Inject 150mg SQ at weeks 0 and 4	1 Refill
	1 carton (150mg/mL)	Maintenance Dose: Inject 150mg SQ every 12 weeks	
STELARA™ <small>Patient eligible for self-injection? Y N</small>	1 carton (1x45mg/0.5mL)	Starter Dose: Inject 45 mg SQ on Day 1 (≤100 kg)	No Refills
	1 carton (1x90mg/mL)	Starter Dose: Inject 90 mg SQ on Day 1 (>100 kg)	
		Maintenance Dose: Inject 45mg SQ once every 12 weeks beginning on Day 29 (≤100kg) Maintenance Dose: Inject 90mg SQ once every 12 weeks beginning on Day 29 (>100kg)	
TALTZ® (Plaque Psoriasis) Autoinjector PFS	3x80mg/ml	Starter Dose: Inject 160mg SQ on Day 0 and 80mg SQ at week 2	No Refills
	2x80mg/ml	Titration Dose: Inject 80mg SQ at weeks 4, 6, 8, 10	1 Refill
	1x80mg/ml	Maintenance Dose: Inject 80mg SQ every 4 weeks starting at week 12	
TALTZ® (Pediatric Plaque Psoriasis) PFS	2x80mg/ml 1x80mg/ml	Starter Dose: Patients >50kg: Inject 160mg at week 0. Begin maintenance dosing at week 4 Patients 25-50kg: Inject 80mg at week 0. Begin maintenance dosing at week 4. Patients <25kg: Inject 40mg at week 0. Begin maintenance dosing at week 4.	
	1x80mg/ml	Maintenance Dose: Patients >50kg: Inject 80mg every 4 weeks Patients 25-50kg: Inject 40mg every 4 weeks Patients <25kg: Inject 20mg every 4 weeks.	
TALTZ® (Psoriatic Arthritis) Autoinjector PFS	2x80mg/ml	Starter Dose: Inject 160mg SQ on Day 0	No Refills
	1x80mg/ml	Maintenance Dose: Inject 80mg SQ every 4 weeks starting at week 4	
TREMFYA® PFS OnePress	2 cartons (2x100mg/mL)	Starter Dose: Inject 100 mg SQ at weeks 0 and 4	No Refills
	1 carton (1x100mg/mL)	Maintenance Dose: Inject 100 mg SQ every 8 weeks	
XOLAIR® PFS Vial <small>Sterile water for injection (to be used with Xolair vials) Number of vials: _____ Refills: _____</small>	PFS: 1 carton (1x150mg/ml) Vial: Number of 150mg vials: _____	Inject 150mg SQ every 4 weeks Inject 300mg SQ every 4 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
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Substitution Permitted

Dispense as Written