meijer specialty pharmacy

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Dermatology (H-S)

Humira®, Ilumya™, Odomzo®, Orencia®, Otezla®, Siliq®, Simponi®, Skyrizi™

Prescriber Information

Ship Meds to: ◯ Patient's Home ◯ Prescriber's Office

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

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯M ◯F	Weight:	Height:	Diabetic: ◯Y ◯N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯Y ◯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/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)	TB/PDD Test Given? ◯Y ◯N	Date of Neg. Test: / /	HBV Positive? ◯Y ◯N	If yes, patient 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
◯ **HUMIRA®** (Plaque Psoriasis) ◯ Pens ◯ PFS	**Pens Only:** ◯ Citrate-Free Starter Kit (1x80mg/0.8ml, 2x40mg/0.4ml)	◯ **Starter Dose:** Inject 80 mg SQ Day 1, then 40mg on day 8, then 1 pen every 2 weeks	No Refills
	◯ Citrate Free: 1 carton (2x40mg/0.4ml)	◯ **Maintenance Dose:** Inject 40 mg SQ every 2 weeks	
◯ **HUMIRA®** (Hidradenitis Suppurativa) ◯ Pens ◯ PFS	**Pens Only:** ◯ Citrate-Free Starter Kit (3x80mg/0.8ml)	**Starter Dose:** ◯ **Adolescents weighing 30-59kg:** Inject 80mg SQ on day 1, 40mg on day 8 and 40mg on day 22 ◯ **Adolescents weighing ≥ 60kg and adults:** Inject 160mg SQ day 1 (or 80mg SQ on day 1 and day 2); then 80mg on day 15; then begin maintenance dosing on day 29	No Refills
	Citrate Free ◯ 2 cartons (4x40mg/0.4ml) ◯ 1 carton (2x80mg/0.8ml) PEN ONLY	**Maintenance Dose:** **Adolescents weighing 30-59kg:** ◯ Inject 40mg SQ **every other** week **Adolescents weighing ≥ 60kg and adults:** ◯ Inject 40mg SQ every week ◯ Inject 80mg SQ every other week	
◯ **ILUMYA™**	◯ 1 carton (1x100mg/mL PFS)	◯ **Starter Dose:** Inject 100mg SQ at week 0. Start maintenance dose at week 4.	No Refills
		◯ **Maintenance Dose:** Inject 100mg SQ every 12 weeks	
◯ **ODOMZO®** ◯ Capsule	◯ 200 mg capsule (30 capsules)	◯ Take 1 capsule (200 mg) by mouth once daily on an empty stomach, at least 1 hour before or 2 hours after a meal	
◯ **ORENCIA®** ◯ Clickject® ◯ PFS	◯ 1 carton (4x125mg/ml)	◯ **Maintenance Dose:** Inject 125 mg SQ once every week	
◯ **OTEZLA®** ◯ Tablet	◯ 30 mg tablet (55 tabs for 28 Day Starter Pack)	◯ **Starter Dose:** Take as directed per package instructions	No Refills
	◯ 30 mg tablet (60 tablets)	◯ **Maintenance Dose:** Take 1 tablet by mouth twice daily	
◯ **SILIQ®** ◯ PFS *Product is limited to certified prescribers enrolled in Siliq REMS	◯ 2 cartons (4x210mg/1.5mL)	◯ **Starter Dose:** Inject 210 mg SQ at weeks 0, 1, and 2 and then every 2 weeks thereafter	No Refills
	◯ 1 carton (2x210mg/1.5mL)	◯ **Maintenance Dose:** Inject 210 mg SQ once every 2 weeks	
◯ **SIMPONI®** ◯ SmartJect® ◯ PFS	◯ 1 carton (1x50mg/0.5ml)	◯ Inject 50 mg SQ once a month	
◯ **SKYRIZI™** ◯ PFS Patient eligible for self-injection? ◯ Yes ◯ No	◯ 2 cartons (2x75mg/0.83ml)	◯ **Starter Dose:** Inject 150mg (2 syringes) SQ at weeks 0 and 4	
	◯ 1 carton (2x75mg/0.83ml)	◯ **Maintenance Dose:** Inject 150mg (2 syringes) SQ every 12 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

Substitution Permitted

Prescriber Signature:	Date

Dispense as Written

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