meijer specialty pharmacy

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Dermatology (A-G)

Cimzia®, Cosentyx®, Dupixent®, Enbrel®

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

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

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)	◯ Basal cell carcinoma (C44.____)	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
◯ **CIMZIA®** ◯ PFS ◯ Vials	◯ 1 starter kit (6x200mg/mL)	◯ **Starter Dose:** Inject 400 mg 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®** ◯ 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	
◯ **ENBREL®** ◯ Mini® ◯ PFS ◯ SureClick® ◯ Vial	◯ 6 cartons (24x50mg/mL)	◯ **Starter Dose:** Inject 50 mg SQ twice a week (72-96 hours apart) x 3 months	**No Refills**
	◯ 1 carton (4x50mg/mL)	◯ **Maintenance Dose:** Inject 50 mg SQ every week	
	◯ **PFS:** 1 carton (4x25mg/0.5mL) ◯ **Vial:** 1 carton (4x25mg/mL)	◯ **Pediatric Dose:** < 63 kg (138 lbs) Inject _____ mg (0.8mg/kg) SQ once a week ◯ **Pediatric Dose:** > 63 kg (138 lbs or more) Inject 50 mg SQ once a week	

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.