

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
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: <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/Diagnosis Code:	<input type="radio"/> Psoriasis Vulgaris (L40.0) <input type="radio"/> Other Psoriasis (L40.8) <input type="radio"/> Psoriasis unspecified (L40.9) <input type="radio"/> Psoriatic Arthritis (L40.5) <input type="radio"/> Hidradenitis Suppurativa (L73.2) <input type="radio"/> Chronic Urticaria (L50.8)						
<input type="radio"/> Atopic Dermatitis (L20.9)	TB/PDD Test Given? <input type="radio"/> Y <input type="radio"/> N	Date of Neg. Test: / /	HBV Positive? <input type="radio"/> Y <input type="radio"/> N	If yes, patient currently treated? <input type="radio"/> Y <input type="radio"/> N			
Prior Treatment? <input type="radio"/> Y <input type="radio"/> N (Provide Information Below)	BSA affected (%):	Affected Areas: <input type="radio"/> Palms <input type="radio"/> Soles <input type="radio"/> Head <input type="radio"/> Neck <input type="radio"/> Genitalia <input type="radio"/> Other:					
Prior Therapy	Reason for Discontinuation of Therapy			Approx Start Date	Approx End Date		
Comorbidities:	Concomitant Medications:			Allergies: <input type="radio"/> NKDA <input type="radio"/> Other:			

Prescription Information			
Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> HUMIRA® (Plaque Psoriasis) <input type="radio"/> Pens <input type="radio"/> PFS	Pens Only: <input type="radio"/> Citrate-Free Starter Kit (1x80mg/0.8ml, 2x40mg/0.4ml)	<input type="radio"/> Starter Dose: Inject 80 mg SQ Day 1, then 40mg on day 8, then 1 pen every 2 weeks	No Refills
	<input type="radio"/> Citrate Free: 1 carton (2x40mg/0.4ml)	<input type="radio"/> Maintenance Dose: Inject 40 mg SQ every 2 weeks	
<input type="radio"/> HUMIRA® (Hidradenitis Suppurativa) <input type="radio"/> Pens <input type="radio"/> PFS	Pens Only: <input type="radio"/> Citrate-Free Starter Kit (3x80mg/0.8ml)	Starter Dose: <input type="radio"/> Adolescents weighing 30-59kg: Inject 80mg SQ on day 1, 40mg on day 8 and 40mg on day 22 <input type="radio"/> 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 <input type="radio"/> 2 cartons (4x40mg/0.4ml) <input type="radio"/> 1 carton (2x80mg/0.8ml) PEN ONLY	Maintenance Dose: <input type="radio"/> Adolescents weighing 30-59kg: <input type="radio"/> Inject 40mg SQ every other week <input type="radio"/> Adolescents weighing ≥ 60kg and adults: <input type="radio"/> Inject 40mg SQ every week <input type="radio"/> Inject 80mg SQ every other week	
<input type="radio"/> ILUMYA™	<input type="radio"/> 1 carton (1x100mg/mL PFS)	<input type="radio"/> Starter Dose: Inject 100mg SQ at week 0. Start maintenance dose at week 4.	No Refills
		<input type="radio"/> Maintenance Dose: Inject 100mg SQ every 12 weeks	
<input type="radio"/> ODOMZO® <input type="radio"/> Capsule	<input type="radio"/> 200 mg capsule (30 capsules)	<input type="radio"/> Take 1 capsule (200 mg) by mouth once daily on an empty stomach, at least 1 hour before or 2 hours after a meal	
<input type="radio"/> ORENCIA® <input type="radio"/> Clickject® <input type="radio"/> PFS	<input type="radio"/> 1 carton (4x125mg/ml)	<input type="radio"/> Maintenance Dose: Inject 125 mg SQ once every week	
<input type="radio"/> OTEZLA® <input type="radio"/> Tablet	<input type="radio"/> 30 mg tablet (55 tabs for 28 Day Starter Pack)	<input type="radio"/> Starter Dose: Take as directed per package instructions	No Refills
	<input type="radio"/> 30 mg tablet (60 tablets)	<input type="radio"/> Maintenance Dose: Take 1 tablet by mouth twice daily	
<input type="radio"/> SILIQ® <input type="radio"/> PFS <small>*Product is limited to certified prescribers enrolled in Siliq REMS</small>	<input type="radio"/> 2 cartons (4x210mg/1.5mL)	<input type="radio"/> Starter Dose: Inject 210 mg SQ at weeks 0, 1, and 2 and then every 2 weeks thereafter	No Refills
	<input type="radio"/> 1 carton (2x210mg/1.5mL)	<input type="radio"/> Maintenance Dose: Inject 210 mg SQ once every 2 weeks	
<input type="radio"/> SIMPONI® <input type="radio"/> SmartJect® <input type="radio"/> PFS	<input type="radio"/> 1 carton (1x50mg/0.5ml)	<input type="radio"/> Inject 50 mg SQ once a month	
<input type="radio"/> SKYRIZI™ <input type="radio"/> PFS Patient eligible for self-injection? <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> 2 cartons (2x75mg/0.83ml)	<input type="radio"/> Starter Dose: Inject 150mg (2 syringes) SQ at weeks 0 and 4	
	<input type="radio"/> 1 carton (2x75mg/0.83ml)	<input type="radio"/> Maintenance Dose: Inject 150mg (2 syringes) SQ every 12 weeks	

Injection Training		
<input type="radio"/> Patient received injection training	<input type="radio"/> Prescriber's office to provide injection training	<input type="radio"/> 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