meijer specialty pharmacy

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www.meijerspecialtypharmacy.com

Dermatology (S-Z)

Stelara®, Taltz®, Tremfya®, Xolair®

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
◯ **STELARA®** ◯ PFS Patient eligible for self-injection? ◯ Yes ◯ No	◯ 1 carton (1x45mg/0.5mL) ◯ 1 carton (1x90mg/mL)	◯ **Starter Dose:** Inject 45 mg SQ on Day 1 (≤100 kg) ◯ **Starter Dose:** Inject 90 mg SQ on Day 1 (>100 kg)	**No Refills**
		◯ **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	**8 Refills**
◯ **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.	**No Refills**
	◯ 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 ◯ Sterile water for injection (to be used with Xolair vials) Number of vials: _____ Refills: _____	◯ **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
Substitution Permitted	Dispense as Written

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