meijer specialty pharmacy

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Gastroenterology (A-N)

Cimzia®, Humira®

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: **Crohn's Disease:** ◯ K50.0___(Crohn's of the **Small** Intestine) ◯ K50.1___(Crohn's of the Large Intestine) ◯ K50.8___(Crohn's of Both Intestines) ◯ K50.9___(Crohn's, Unspecified)

Ulcerative Colitis: ◯ K51.0___(Ulcerative Pancolitis) ◯ K51.2___(Ulcerative Procolitis) ◯ K51.3___(Ulcerative Rectosigmoiditis) ◯ K51.5___(Left Sided Colitis) ◯ K51.8___(Other Ulcerative Colitis)

◯ K51.9___ (Ulcerative Colitis, Unspecified) ◯ K58.0___ (Irritable Bowel Syndrome with Diarrhea) ◯ Other:

Date of Diagnosis: / /	Date of Negative TB Test: / /	Prior Treatment? ◯ Y ◯ N **(Provide Information Below)**

Prior Therapy:	Reason for Discontinuation of Therapy:	Approx. Start Date: / /
		Approx. End Date: / /

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **CIMZIA®** ◯ **PFS** ◯ **Vials**	◯ Prefilled Syringe Starter Kit (6x200mg/ml) ◯ 1 carton (2x200mg/ml)	◯ **Starter Dose:** Inject 400mg SQ at weeks 0, 2, and 4 ◯ **Maintenance Dose:** Inject 400mg SQ every 4 weeks ◯ **Maintenance Dose:** Inject 200mg SQ every 2 weeks	
◯ **HUMIRA®** ◯ **Pen** ◯ **PFS**	**Pens Only:** ◯ Citrate Free Starter Kit (3x80mg/0.8ml)	**Starter Dose (children ≥ 40kg and adults):** ◯ Inject 160mg SQ on day 1, then 80mg on day 15, then begin maintenance dosing on day 29 ◯ Inject 80mg SQ on days 1 and 2, then 80mg on day 15, then begin maintenance dosing on day 29	**No Refills**
	◯ Citrate Free 1 carton (2x40mg/0.4ml)	◯ **Maintenance Dose:** Inject 40mg SQ every 14 days	
◯ **HUMIRA®** **Pediatrics Crohn's Disease*	**Starter Kit:** ◯ 1 carton (3x80mg/0.8mL PFS) ◯ 1 carton (1x80mg/0.8mL + 1x40mg/0.4ml PFS)	**Starter Dose:** Weight 15-29kg: ◯ Inject 80mg SQ on day 1, then 40mg on day 15, then begin maintenance dosing on day 29 **Starter Dose:** Weight ≥ 40kg: ◯ Inject 160mg on day 1, then 80mg on day 15, then begin maintenance dosing on day 29 ◯ Inject 80mg SQ on days 1 and 2, then 80mg on day 15, then begin maintenance dosing on day 2	**No Refills**
	◯ 1 carton (2x20mg/0.2mL PFS) ◯ 1 carton (2x40mg/0.4mL PFS) ◯ 1 carton (2x40mg/0.4mL PEN)	**Maintenance Dose:** ◯ Inject 20mg SQ every 14 days ◯ Inject 40mg SQ every 14 days	
◯ **HUMIRA®** **Pediatrics Ulcerative Colitis Disease*	**Starter Dose:** Weight 15-29kg: ◯ 2 cartons (4X40mg/0.4ml PEN)	**Starter Dose:** Weight 15-29kg: ◯ Inject 80mg SQ on day 1, then 40mg on day 8, then 40mg on day 15. Begin maintenance dosing on day 29	**No Refills**
	Starter Kit: Weight ≥ 40kg ◯ 1 carton (4x80mg/0.8ml) PEN	Weight ≥40kg ◯ Inject 160mg SQ on day 1, then 80mg on day 8, then 80mg on day 15. Begin maintenance dosing on day 29. ◯ Inject 80mg SQ on days 1 and 2, then 80mg on day 8, then 80mg on day 15. Begin maintenance dosing on day 29.	**No Refills**
	◯ 2 cartons (4x20mg/0.2mL PFS) ◯ 1 carton (2x40mg/0.4mL PFS) ◯ 1 carton (2x40mg/0.4mL PEN) ◯ 2 cartons (4x40mg/0.4mL PFS) ◯ 2 cartons (4x40mg/0.4mL PEN) ◯ 1 carton (2x80mg/0.8mL PEN)	**Maintenance Dose:** Weight 20-39kg: ◯ Inject 40mg SQ every other week ◯ Inject 20mg SQ every week **Maintenance Dose:** Weight ≥40kg: ◯ Inject 80mg SQ every other week ◯ Inject 20mg SQ every 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	Prescriber Signature	Date

Substitution Permitted

Dispense as Written

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