meijer specialty pharmacy

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# Gastroenterology (O-Z)

## Prescriber Information

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

| Prescriber Name: | | | ◯MD ◯DO ◯NP ◯PA | NPI: |
|---|---|---|---|---|
| Office Contact: | | Practice Name / Supervising 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:** **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: / / | Any prior treatment? ◯ Yes ◯ No (provide information below) |
|---|---|---|

| Prior Therapy | Reason for Discontinuation of Therapy |
|---|---|

## Prescription Information

| Medication | Quantity/Strength | Sig | Refills |
|---|---|---|---|
| ◯ **SIMPONI®**<br>◯ SmartJect ◯ PFS | ◯ 1 carton (1x50mg/0.5ml PFS)<br>◯ 1 carton (1x100mg/ml PFS)<br>◯ 1 carton (1x50mg/0.5ml Autoinjector)<br>◯ 1 carton (1x100mg/ml Autoinjector) | ◯ **Starter Dose:** Inject 200 mg SQ at week 0; then 100 mg at week 2<br>◯ **Maintenance Dose:** Inject 100mg SQ every 4 weeks, starting at week 6 | |
| ◯ **STELARA®** | ◯ 1 carton (1x45mg/0.5ml PFS)<br>◯ 1 carton (1x90mg/ml PFS) | **Maintenance Dose:**<br>◯ Inject 0.5ml (45mg) SQ 8 weeks after infusion, then every 8 weeks thereafter<br>◯ Inject 1ml (90mg) SQ 8 weeks after infusion, then every 8 weeks thereafter | |
| ◯ **XELJANZ®** | ◯ 10mg tablets (quantity QS for length of starter dose therapy, in multiples of 60 tablets) | ◯ **Starter Dose:** Take 10mg by mouth twice daily for ____ weeks | No Refills |
| | ◯ 5mg tablets (30 day supply)<br>◯ 10mg tablets (30 day supply) | ◯ **Maintenance Dose:** Take 1 tablet by mouth two times a day | |
| ◯ **XELJANZ® XR** | ◯ 22mg tablets (quantity QS for length of starter dose therapy, in multiples of 30 tablets) | ◯ **Starter Dose:** Take 22mg by mouth once daily for _____ weeks | No Refills |
| | ◯ 11mg tablets (30 day supply) | ◯ **Maintenance Dose:** Take 11mg by mouth once daily | |
| ◯ **XIFAXAN®** | ◯ 200mg tablet ◯ 550mg tablet | ◯ Take 1 tablet by mouth 2 times a day for ______ days<br>◯ Take 1 tablet by mouth 3 times a day for ______ days | |

## 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.