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IV - Dermatology, Gastroenterology, Rheumatology

Benlysta®, Entyvio®, Krystexxa®, Orencia®, Remicade®, Rituxan®, Simponi Aria®, Stelara®

Prescriber Information

Send updates to: ◯ Fax: _____ ◯ Email: _____

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		
Primary Insurance:		Policy ID:	Group #:			
Policyholder Name:		Policyholder DOB:	BIN:	PCN:		

Prior Therapy:	Reason for Discontinuation of Therapy:
Comorbidities:	Concomitant Medications:

Dermatology | 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:

Allergies: ◯ NKDA ◯ Other: | Approximate Start Date | Approximate End Date

Gastroenterology | 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)

Rheumatology | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

Diagnosis: ◯ M32.9 Active Systemic Lupus Erythematosus ◯ M45.9 Ankylosing Spondylitis ◯ M08.0 Juvenile Idiopathic Arthritis ◯ L40.59 Psoriatic Arthritis ◯ L40.54 Psoriatic Juvenille Arthritis

◯ M06.9 Rheumatoid Arthritis ◯ H20 Iridocyclitis (Uveitis) ◯ Other: | Date of Diagnosis: / / | Date of Negative TB Test: / /

Any prior treatment? ◯ Yes ◯ No (provide information below) | Allergies: ◯ NKDA ◯ Other: | Approx. Start Date | Approx. End Date

Prescription Information

TREATMENT ARRANGEMENTS: Ship Meds: ◯ Home ◯ Doctor's Office Start Date: / /

Medication	Dose/Strength	Sig	Refills
◯ **BENLYSTA®**	◯ Number of 120mg/5ml vials: _____ ◯ Number of 400mg/20ml vials: _____	◯ **Starter Dose:** Infuse _____mg IV over 1 hour at weeks 0, 2, and 4	No Refills
		◯ **Maintenance Dose:** Infuse _____mg IV over 1 hour once every 4 weeks	
◯ **ENTYVIO®**	◯ Starter dose: 2 vials	◯ **Starter dose:** Infuse 300mg IV over 30 minutes at weeks 0 and 2	No Refills
	◯ Maintenance dose: Number of 300mg vials: _____	◯ **Maintenance dose:** Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6	
◯ **KRYSTEXXA®**	◯ Number of 8mg/ml vials: _____	◯ Infuse 8mg IV over 2 hours every 2 weeks	
◯ **ORENCIA®**	◯ Number of 250mg vials: _____	◯ **Starter Dose:** Infuse _____ mg IV in 100ml NS over 30 minutes at weeks 0 and 2	No Refills
		◯ **Maintenance Dose:** Infuse _____mg IV in 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter	
◯ **REMICADE®**	◯ Number of 100mg vials: _____	◯ **Starter Dose:** Infuse _____mg IV over 2 hours at weeks 0, 2 and 6	No Refills
		◯ **Maintenance Dose:** Infuse _____mg IV over 2 hours once every _____ weeks	
◯ **RITUXAN®**	◯ Number of 100mg/10ml vials: _____ ◯ Number of 500mg/50ml vials: _____	◯ **Starter dose:** Infuse 1000mg IV over 4-6 hours on day 1 and day 15	No Refills
		◯ **Maintenance dose:** Infuse 1000mg IV over 4-6 hours every _____ weeks	
◯ **SIMPONI ARIA®**	◯ Number of 50mg/4ml vials: _____	◯ **Starter Dose:** Infuse _____ mg IV over 30 minutes at weeks 0 and 4	No Refills
		◯ **Maintenance Dose:** Infuse _____ mg IV over 30 minutes once every 8 weeks	
◯ **STELARA®**	◯ Number of 45mg/0.5ml vials: _____ ◯ Number of 130mg/26ml vials: _____	**Starter Dose:** ◯ Weight > 85kg: Infuse 520mg IV over 1 hour ◯ Weight 56kg – 85kg: Infuse 390mg IV over 1 hour ◯ Weight ≤ 55kg: Infuse 260mg IV over 1 hour Begin the SQ maintenance regimen 8 weeks after the initial IV dose	No Refills

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