

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		NPI:
Office Contact:			Practice Name / Collaborating Physician:		
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

Diagnosis:	ICD-10:	Patient's Previous Treatment:			
Urine Drug Screen Attached: <input type="radio"/> Y <input type="radio"/> N	Date of Diagnosis: / /	Transplant: <input type="radio"/> Y <input type="radio"/> N	Transplant Type:		
Biopsy: <input type="radio"/> Y <input type="radio"/> N	Fibrosis:	Scale (0-4):	Genotype:	Initial Viral Load: IU/ml	Date: / / HIV: <input type="radio"/> Y <input type="radio"/> N
Hepatitis B Testing Completed: <input type="radio"/> Y <input type="radio"/> N	Date Taken: / /	Result: <input type="radio"/> Positive <input type="radio"/> Negative			
RAV Testing Completed: <input type="radio"/> Y <input type="radio"/> N	Date Taken: / /	Resistance Variants found:			
TREATMENT ARRANGEMENTS:	Start Date: / /	Length of Therapy: <input type="radio"/> 8 weeks <input type="radio"/> 12 weeks <input type="radio"/> Other			

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
<input type="radio"/> VEMLIDY®	<input type="radio"/> 25mg tablet	<input type="radio"/> Take 1 tablet by mouth once daily with food	30 Day Supply	
<input type="radio"/> VOSEVI™	<input type="radio"/> 400mg/100mg/100mg tablet	<input type="radio"/> Take 1 tablet by mouth daily with food	28 Day Supply	
<input type="radio"/> XIFAXAN®	<input type="radio"/> 550mg tablet	<input type="radio"/> Take 1 tablet by mouth 2 times a day	30 Day Supply	
<input type="radio"/> ZEPATIER™	<input type="radio"/> 50mg / 100mg tablet	<input type="radio"/> Take 1 tablet by mouth once daily with or without food	28 Day Supply	
<input type="radio"/> Other:				
<input type="radio"/> Other:				

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

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