

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**

ICD-10 Code:	Weight _____ <input type="radio"/> lb / <input type="radio"/> kg	Height _____ <input type="radio"/> in / <input type="radio"/> cm	BSA _____ m <sup>2</sup>	Diagnosis Date: / /
Current SCR _____ or current GFR _____ ml/min	Confirmed Mutations:			
Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date	

**Prescription Information**

Medication	Dose/Strength	Sig (Please Include Cycle)	Quantity	Refills
<input type="radio"/> <b>IXEMPRA®</b> (ixabepilone)	<input type="radio"/> 15mg vial <input type="radio"/> 45mg vial			
<input type="radio"/> <b>JEVTANA®</b> (cabazitaxel)	<input type="radio"/> 60mg vial			
<input type="radio"/> <b>KEYTRUDA®</b> (pembrolizumab)	<input type="radio"/> 100mg/4mL vial			
<input type="radio"/> <b>OPDIVO®</b> (nivolumab)	<input type="radio"/> 40mg vial <input type="radio"/> 100mg vial <input type="radio"/> 240mg vial			
<input type="radio"/> <b>PERJETA®</b> (pertuzumab)	<input type="radio"/> 420mg vial			
<input type="radio"/> <b>POLIVY™</b> (polatuzumab vedotin-piiq)	<input type="radio"/> 140mg vial			
<input type="radio"/> <b>RITUXAN®</b> (rituximab) Biosimilar: <input type="radio"/> Ruxience®	<input type="radio"/> 100mg/10mL vial <input type="radio"/> 500mg/50mL vial			
<input type="radio"/> <b>TORISEL®</b> (temsirolimus)	<input type="radio"/> 25mg/mL vial			
<input type="radio"/> <b>VELCADE®</b> (bortezomib)	<input type="radio"/> 3.5mg vial			
<input type="radio"/> <b>VIDAZA®</b> (azacytidine)	<input type="radio"/> 100mg vial			
<input type="radio"/> <b>YERVOY®</b> (ipilimumab)	<input type="radio"/> 10mL vial (5mg/mL) <input type="radio"/> 40mL vial (5mg/mL)			
<input type="radio"/> <b>ZALTRAP®</b> (ziv-aflibercept)	<input type="radio"/> 100mg vial <input type="radio"/> 200mg vial			
<input type="radio"/> <b>ZOLEDRONIC ACID</b>	<input type="radio"/> 4mg/100mL vial			
<input type="radio"/> <b>OTHER:</b>				

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.