

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		

Clinical Information | 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 Juvenile Arthritis M06.9 Rheumatoid Arthritis M46.8 Non-Radiographic Axial Spondyloarthritis Other:

Date of Diagnosis: / / Date of Negative TB Test: / / Any prior treatment? Yes No (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: Concomitant Medications:

Allergies: NKDA Other:

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

Prescription Information

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> TALTZ [®] <input type="radio"/> Autoinjector <input type="radio"/> PFS	Starter Dose: <input type="radio"/> 2x80mg/ml Maintenance Dose: <input type="radio"/> 1x80mg/ml <input type="radio"/> 3x80mg/ml	<input type="radio"/> Starter Dose: Inject 160mg SQ at week 0 <input type="radio"/> Maintenance Dose: Inject 80mg SQ every 4 weeks	No Refills
<input type="radio"/> TREMFYA [®] <input type="radio"/> PFS <input type="radio"/> OnePress	<input type="radio"/> 2 cartons (2x100mg/mL) <input type="radio"/> 1 carton (1x100mg/mL)	<input type="radio"/> Starter Dose: Inject 100 mg SQ at weeks 0 and 4 <input type="radio"/> Maintenance Dose: Inject 100 mg SQ every 8 weeks	No Refills
<input type="radio"/> XELJANZ [®]	<input type="radio"/> 5 mg tablets (60 tablets)	<input type="radio"/> Take 1 tablet (5 mg) by mouth twice a day	
<input type="radio"/> XELJANZ [®] XR	<input type="radio"/> 11 mg tablets (30 tablets)	<input type="radio"/> Take 1 tablet (11mg) by mouth every day	

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
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Substitution Permitted

Dispense as Written