

**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 MD:		
Address:		City:	State:	Zip:
Phone:	Fax:			

**Patient Information • PLEASE SEND COPY OF INSURANCE CARD**

Patients 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
Office Contact:		Practice Name / Collaborating MD:				
Address:		City:	State:	Zip:		
Home Phone:	Work/Cell:	HIPPA Contact:		Emergency #:		
Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N	Allergies: <input type="radio"/> Y <input type="radio"/> N If Yes, list allergies:					

**Insurance Information**

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

**Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES**

<b>Diagnosis</b>	<input type="radio"/> M32.9 Active Systemic Lupus Erythematosus <input type="radio"/> M45.9 Ankylosing Spondylitis <input type="radio"/> M08.0 Juvenile Idiopathic Arthritis <input type="radio"/> L40.59 Psoriatic Arthritis <input type="radio"/> L40.54 Psoriatic Juvenile Arthritis				
<input type="radio"/> M06.9 Rheumatoid Arthritis <input type="radio"/> M46.8 Non-Radiographic Axial Spondyloarthritis <input type="radio"/> Other:					
Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? <input type="radio"/> Y <input type="radio"/> N If Yes, provide information below			
Prior Therapy:	Reason for Discontinuation of Therapy:		Approximate Start Date:	Approximate End Date:	
Comorbidities:			Concomitant Medications:		
Allergies: <input type="radio"/> NKDA <input type="radio"/> Other:		Treatment Arrangements	Ship Meds: <input type="radio"/> Home <input type="radio"/> Prescribers Office	Start Date: / /	

**Prescription Information**

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> <b>TALTZ®</b> <input type="radio"/> Autoinjector <input type="radio"/> PFS	<b>Starter Dose:</b> <input type="radio"/> 2x80mg/ml	<input type="radio"/> <b>Starter Dose:</b> Inject 160mg SQ at week 0	<b>No Refills</b>
	<b>Maintenance Dose:</b> <input type="radio"/> 1x80mg/ml <input type="radio"/> 3x80mg/ml	<input type="radio"/> <b>Maintenance Dose:</b> Inject 80mg SQ every 4 weeks	
<input type="radio"/> <b>TREMFYA®</b> <input type="radio"/> PFS <input type="radio"/> OnePress	<input type="radio"/> 2 cartons (2x100mg/mL)	<input type="radio"/> <b>Starter Dose:</b> Inject 100 mg SQ at weeks 0 and 4	<b>No Refills</b>
	<input type="radio"/> 1 carton (1x100mg/mL)	<input type="radio"/> <b>Maintenance Dose:</b> Inject 100 mg SQ every 8 weeks	
<input type="radio"/> <b>XELJANZ®</b> <i>*Pediatrics (age 2 &amp; up)</i>	<input type="radio"/> 5mg tablets (60 tablets)	<input type="radio"/> <b>Weight 10-19kg:</b> Take 3.2mg (3.2ml oral solution) by mouth two times daily	
	<input type="radio"/> 1mg/ml oral solution (quantity QS for 30 day supply in multiples of 240ml)	<input type="radio"/> <b>Weight 20-39kg:</b> Take 4mg (4ml oral solution) by mouth two times daily	
		<input type="radio"/> <b>Weight ≥ 40kg:</b> Take 5mg by mouth two times daily	
<input type="radio"/> <b>XELJANZ®</b> <input type="radio"/> PFS <input type="radio"/> OnePress	<input type="radio"/> 5 mg tablets (60 tablets)	<input type="radio"/> Take 1 tablet (5 mg) by mouth twice a day	
<input type="radio"/> <b>XELJANZ® XR</b>	<input type="radio"/> 11 mg tablets (30 tablets)	<input type="radio"/> Take 1 tablet (11mg) by mouth every day	

**Injection Training**

<input type="radio"/> Patient received injection training	<input type="radio"/> Prescriber's office to provide injection training	<input type="radio"/> Meijer to coordinate injection training
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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.