

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"/> KEVZARA® <input type="radio"/> PFS <input type="radio"/> Pen	<input type="radio"/> 1 carton (2x200mg/1.14ml) <input type="radio"/> 1 carton (2x150mg/1.14ml)	<input type="radio"/> Inject 200mg SQ every 2 weeks <input type="radio"/> Inject 150mg SQ every 2 weeks	
<input type="radio"/> OLUMIANT®	<input type="radio"/> 2mg tablet (30 day supply)	<input type="radio"/> Take 1 tablet by mouth once daily	
<input type="radio"/> ORENCIA® <input type="radio"/> Clickject® <input type="radio"/> PFS	<input type="radio"/> 1 carton (4x125mg/ml)	<input type="radio"/> <b>Maintenance Dose:</b> Inject 125 mg SQ once every week	
<input type="radio"/> OTEZLA®	<input type="radio"/> Starter Pack 10/20/30mg tablets (55 tabs for 28 days)	<input type="radio"/> <b>Starter Dose:</b> Take as directed per package instructions	No Refills
	<input type="radio"/> 30 mg tablet (60 tablets)	<input type="radio"/> <b>Maintenance Dose:</b> Take 1 tablet (30mg) by mouth twice daily	
<input type="radio"/> OTREXUP™ <input type="radio"/> Auto-injector	<input type="radio"/> 1 carton (4x10mg/0.4ml)	<input type="radio"/> Inject _____mg SQ every week	
	<input type="radio"/> 1 carton (4x12.5mg/0.4ml)		
	<input type="radio"/> 1 carton (4x15mg/0.4ml)		
	<input type="radio"/> 1 carton (4x17.5mg/0.4ml)		
<input type="radio"/> RASUVO® <input type="radio"/> Auto-injector	<input type="radio"/> 4x7.5mg/0.15ml	<input type="radio"/> Inject _____mg SQ every week	
	<input type="radio"/> 4x10mg/0.20ml		
	<input type="radio"/> 4x12.5mg/0.25ml		
	<input type="radio"/> 4x15mg/0.30ml		
	<input type="radio"/> 4x17.5mg/0.35ml		
	<input type="radio"/> 4x20mg/0.4ml		
<input type="radio"/> 4x22.5mg/0.45ml			
<input type="radio"/> 4x25mg/0.50ml			
<input type="radio"/> 4x30mg/0.60ml			
<input type="radio"/> RINVOQ™	<input type="radio"/> 15mg tablet (30 day supply)	<input type="radio"/> Take 1 tablet by mouth once daily	
<input type="radio"/> SIMPONI® <input type="radio"/> SmartJect® <input type="radio"/> PFS	<input type="radio"/> 1 carton (1x50mg/0.5ml)	<input type="radio"/> Inject 50 mg SQ once every month	
<input type="radio"/> STELARA® <input type="radio"/> PFS Patient eligible for self-injection? <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> 1 carton (1x45mg/0.5ml)	<input type="radio"/> <b>Starter Dose:</b> Inject 45 mg SQ on day 1 (<100kg)	No Refills
	<input type="radio"/> 1 carton (1x90mg/ml)	<input type="radio"/> <b>Starter Dose:</b> Inject 90 mg SQ on day 1 (>100kg)	
		<input type="radio"/> <b>Maintenance Dose:</b> Inject 45 mg SQ on day 29 and every 12 weeks thereafter (<100kg)	
		<input type="radio"/> <b>Maintenance Dose:</b> Inject 90 mg SQ on day 29 and every 12 weeks thereafter (>100kg)	

**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
-----------------------	------	-----------------------	------

Substitution Permitted

Dispense as Written