meijer specialty pharmacy

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Rheumatology (K-S)

Kevzara®, Olumiant®, Orencia®, Otezla®, Otrexup™, Rasuvo®, Rinvoq™, Simponi®, Stelara®,

Prescriber Information

Prescriber Name:	◯ MD ◯ DO ◯ NP ◯ 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: ◯ M ◯ F	Weight:	Height:	Diabetic? ◯ Y ◯ N
Office Contact:	Practice Name / Collaborating MD:					
Address:	City:	State:	Zip:			
Home Phone:	Work/Cell:	HIPPA Contact:	Emergency #:			
Interpreter Needed? ◯ Y ◯ N	Allergies: ◯ Y ◯ 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

Diagnosis

◯ M32.9 Active Systemic Lupus Erythematosus ◯ M45.9 Ankylosing Spondylitis ◯ M08.0 Juvenile Idiopathic Arthritis ◯ L40.59 Psoriatic Arthritis ◯ L40.54 Psoriatic Juvenille Arthritis

◯ M06.9 Rheumatoid Arthritis ◯ M46.8 Non-Radiographic Axial Spondyloarthritis ◯ Other:

Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? ◯ Y ◯ N **If Yes, 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 ◯ Prescribers Office	Start Date: / /

Prescription Information

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

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