meijer specialty pharmacy

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Rheumatology (T-Z)

Taltz®, Tremfya®, Xeljanz®, Xeljanz® XR

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

Substitution Permitted

Dispense as Written

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