

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	
Office Contact:	NPI:	
Address:	Practice Name / Collaborating MD:	
City:	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			

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

Clinical Information PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES							
ICD-10/Diagnosis Code:	<input type="radio"/> Psoriasis Vulgaris (L40.0) <input type="radio"/> Other Psoriasis (L40.8) <input type="radio"/> Psoriasis unspecified (L40.9) <input type="radio"/> Psoriatic Arthritis (L40.5) <input type="radio"/> Hidradenitis Suppurativa (L73.2) <input type="radio"/> Chronic Urticaria (L50.8)						
<input type="radio"/> Atopic Dermatitis (L20.9)	TB/PDD Test Given? <input type="radio"/> Y <input type="radio"/> N	Date of Neg. Test: / /	HBV Positive? <input type="radio"/> Y <input type="radio"/> N	If yes, patient currently treated? <input type="radio"/> Y <input type="radio"/> N			
Prior Treatment? <input type="radio"/> Y <input type="radio"/> N (Provide Information Below)	BSA affected (%):	Affected Areas: <input type="radio"/> Palms <input type="radio"/> Soles <input type="radio"/> Head <input type="radio"/> Neck <input type="radio"/> Genitalia <input type="radio"/> Other:					
Prior Therapy	Reason for Discontinuation of Therapy			Approx Start Date	Approx End Date		
Comorbidities:	Concomitant Medications:			Allergies: <input type="radio"/> NKDA <input type="radio"/> Other:			

Prescription Information			
Medication	Quantity/Dose	Sig	Refills
<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"/> Starter Dose: Inject 45 mg SQ on Day 1 (≤100 kg)	No Refills
	<input type="radio"/> 1 carton (1x90mg/mL)	<input type="radio"/> Starter Dose: Inject 90 mg SQ on Day 1 (>100 kg)	
<input type="radio"/> TALTZ® *Plaque Psoriasis <input type="radio"/> Autoinjector <input type="radio"/> PFS	<input type="radio"/> 3x80mg/ml	<input type="radio"/> Starter Dose: Inject 160mg SQ on Day 0 and 80mg SQ at week 2	No Refills
	<input type="radio"/> 2x80mg/ml	<input type="radio"/> Titration Dose: Inject 80mg SQ at weeks 4, 6, 8, 10	1 Refill
	<input type="radio"/> 1x80mg/ml	<input type="radio"/> Maintenance Dose: Inject 80mg SQ every 4 weeks starting at week 12	8 Refills
<input type="radio"/> TALTZ® *Pediatric Plaque Psoriasis <input type="radio"/> PFS	<input type="radio"/> 2x80mg/ml	Starter Dose:	No Refills
	<input type="radio"/> 1x80mg/ml	<input type="radio"/> Patients >50kg: Inject 160mg at week 0. Begin maintenance dosing at week 4	
	<input type="radio"/> 1x80mg/ml	<input type="radio"/> Patients 25-50kg: Inject 80mg at week 0. Begin maintenance dosing at week 4.	
<input type="radio"/> TALTZ® *Psoriatic Arthritis <input type="radio"/> Autoinjector <input type="radio"/> PFS	<input type="radio"/> 2x80mg/ml	<input type="radio"/> Starter Dose: Inject 160mg SQ on Day 0	No Refills
	<input type="radio"/> 1x80mg/ml	<input type="radio"/> Maintenance Dose: Inject 80mg SQ every 4 weeks starting at week 4	
<input type="radio"/> TREMFYA® <input type="radio"/> PFS <input type="radio"/> OnePress	<input type="radio"/> 2 cartons (2x100mg/mL)	<input type="radio"/> Starter Dose: Inject 100 mg SQ at weeks 0 and 4	No Refills
	<input type="radio"/> 1 carton (1x100mg/mL)	<input type="radio"/> Maintenance Dose: Inject 100 mg SQ every 8 weeks	
<input type="radio"/> XOLAIR® <input type="radio"/> PFS <input type="radio"/> Vial <input type="radio"/> Sterile water for injection (to be used with Xolair vials) Number of vials: _____ Refills: _____	<input type="radio"/> PFS: 1 carton (1x150mg/ml)	<input type="radio"/> Inject 150mg SQ every 4 weeks	
	<input type="radio"/> Vial: Number of 150mg vials: _____	<input type="radio"/> Inject 300mg SQ every 4 weeks	

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

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.