meijer specialty pharmacy

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Pulmonology

Prescriber Information

Ship Meds to: ◯ Patient's Home ◯ Prescriber's Office

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:		Practice Name / Supervising MD:	
Address:		City:	
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ 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:	◯ Primary Pulmonary Hypertension (I27.0) ◯ Idiopathic PAH ◯ Familial PAH
	◯ Secondary Pulmonary Arterial Hypertension (I27.21) ◯ Congenital heart disease ◯ Connective tissue disorder ◯ HIV ◯ Other: _____

Prior Treatment? ◯ Y ◯ N (Provide Information Below)	Approximate Start Date	Approximate End Date

Prior Therapy	Reason for Discontinuation of Therapy
Comorbidities:	Concomitant Medications:

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **ADCIRCA**® (tadalafil)	◯ 20mg tablet ◯ 30 day supply ◯ 90 day supply	◯ Take 2 tablets (40mg) by mouth daily ◯ Other: _____	
◯ **BOSENTAN** (generic Tracleer®)	◯ 62.5mg tablet	**Starter Dose** ◯ Take 62.5mg two times a day for 4 weeks	No Refills
	◯ 125mg tablet ◯ 30 day supply ◯ 90 day supply ◯ 62.5mg tablet ◯ 30 day supply ◯ 90 day supply	**Maintenance Dose:** ◯ Patients >12 years old and >40kg: Take 125mg two times a day ◯ Patients > 12 years old and <40kg: Take 62.5mg two times a day ◯ Other: _____	
◯ **REVATIO**® (sildenafil)	◯ 20mg tablet ◯ 30 day supply ◯ 90 day supply	◯ Take 1 tablet by mouth three times a day ◯ Other: _____	
	◯ 10mg/ml oral suspension ◯ 30 day supply ◯ 90 day supply	◯ Take 5mg (0.5ml) by mouth three times a day ◯ Other: _____	

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.