meijer specialty pharmacy

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# Dermatology (S-Z)

**Siliq®, Simponi®, Skyrizi™, Stelara™, Taltz®, Tremfya®, Xolair®**

## 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

| | | | | |
|---|---|---|---|---|
| **ICD-10/Diagnosis Code:** ◯ Psoriasis Vulgaris (L40.0) ◯ Other Psoriasis (L40.8) ◯ Psoriasis unspecified (L40.9) ◯ Psoriatic Arthritis (L40.5) ◯ Hidradenitis Suppurativa (L73.2) ◯ Chronic Urticaria (L50.8) | | | | |
| ◯ Atopic Dermatitis (L20.9) ◯ Basal cell carcinoma (C44.____) | TB/PDD Test Given: ◯ Y ◯ N | Date of Neg. Test: / / | HBV Positive? ◯ Y ◯ N **If Yes, is patent currently treated?** ◯ Y ◯ N | |
| Prior Treatment? ◯ Y ◯ N **(Provide Information Below)** | BSA Affected (%): | Affected Areas: ◯ Palms ◯ Soles ◯ Head ◯ Neck ◯ Genitalia ◯ Other: | | |
| Prior Therapy: | Reason for Discontinuation of Therapy: | Approx. Start Date: / / | | |
| | | Approx. End Date: / / | | |
| Comorbidities: | Concomitant Medications: | Allergies: ◯ NKDA ◯ Other: | | |

## Prescription Information

| Medication | | Quantity/Dose | Sig | Refills |
|---|---|---|---|---|
| ◯ **SILIQ®** | *Product is limited to certified prescribers enrolled in Siliq REMS | ◯ 2 cartons (4x210mg/1.5mL) | ◯ **Starter Dose:** Inject 210 mg SQ at weeks 0, 1, and 2 and then every 2 weeks after | **No Refills** |
| | | ◯ 1 carton (2x210mg/1.5mL) | ◯ **Maintenance Dose:** Inject 210 mg SQ once every 2 weeks | |
| ◯ **SIMPONI®** | ◯ SmartJect® ◯ PFS | ◯ 1 carton (1x50mg/0.5ml) | ◯ Inject 50 mg SQ once a month | |
| ◯ **SKYRIZI™** | ◯ PFS ◯ Pen | ◯ 1 carton (150mg/mL) | ◯ **Starter Dose:** Inject 150mg SQ at weeks 0 and 4 | **1 Refill** |
| | | ◯ 1 carton (150mg/mL) | ◯ **Maintenance Dose:** Inject 150mg SQ every 12 weeks | |
| ◯ **STELARA™** | 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 (≤100 kg) ◯ **Starter Dose:** Inject 90 mg SQ on Day 1 (>100 kg) | **No Refills** |
| | | | ◯ **Maintenance Dose:** Inject 45mg SQ once every 12 weeks beginning on Day 29 (≤100kg) ◯ **Maintenance Dose:** Inject 90mg SQ once every 12 weeks beginning on Day 29 (>100kg) | |
| ◯ **TALTZ®** (Plaque Psoriasis) | ◯ Autoinjector ◯ PFS | ◯ 3x80mg/ml | ◯ **Starter Dose:** Inject 160mg SQ on Day 0 and 80mg SQ at week 2 | **No Refills** |
| | | ◯ 2x80mg/ml | ◯ **Titration Dose:** Inject 80mg SQ at weeks 4, 6, 8, 10 | **1 Refill** |
| | | ◯ 1x80mg/ml | ◯ **Maintenance Dose:** Inject 80mg SQ every 4 weeks starting at week 12 | |
| ◯ **TALTZ®** (Pediatric Plaque Psoriasis) | ◯ PFS | ◯ 2x80mg/ml ◯ 1x80mg/ml | **Starter Dose:** ◯ Patients >50kg: Inject 160mg at week 0. Begin maintenance dosing at week 4 ◯ Patients 25-50kg: Inject 80mg at week 0. Begin maintenance dosing at week 4. ◯ Patients <25kg: Inject 40mg at week 0. Begin maintenance dosing at week 4. | |
| | | ◯ 1x80mg/ml | **Maintenance Dose:** ◯ Patients >50kg: Inject 80mg every 4 weeks ◯ Patients 25-50kg: Inject 40mg every 4 weeks ◯ Patients <25kg: Inject 20mg every 4 weeks. | |
| ◯ **TALTZ®** (Psoriatic Arthritis) | ◯ Autoinjector ◯ PFS | ◯ 2x80mg/ml | ◯ **Starter Dose:** Inject 160mg SQ on Day 0 | **No Refills** |
| | | ◯ 1x80mg/ml | ◯ **Maintenance Dose:** Inject 80mg SQ every 4 weeks starting at week 4 | |
| ◯ **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 | |
| ◯ **XOLAIR®** ◯ PFS ◯ Vial ◯ Sterile water for injection (to be used with Xolair vials) Number of vials: _____ Refills: _____ | | ◯ **PFS:** 1 carton (1x150mg/ml) ◯ **Vial:** Number of 150mg vials: _____ | ◯ Inject 150mg SQ every 4 weeks ◯ Inject 300mg SQ every 4 weeks | |

## 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.**