

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
Address:		City:		State:	Zip:		
Home Phone:		Work/Cell:	HIPPA Contact:		Emergency #:		
Interpreter Needed? Y N	Allergies: Y N <b>If Yes, list allergies:</b>						

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:	Alopecia areata (L63)	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.____) Other:					
TB/PDD Test Given: Y N	Date of Neg. Test: / /	HBV Positive? Y N <b>If Yes, is patent currently treated? Y N</b>			
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
<b>CIBINQO™</b>	50mg tablet (30 day supply) 100mg tablet (30 day supply) 200mg tablet (30 day supply)	Take 1 tablet by mouth daily	
<b>CIMZIA®</b> PFS Vials	1 starter kit (6x200mg/ml)	<b>Starter Dose:</b> Inject 400mg SQ at weeks 0, 2 and 4	<b>No Refills</b>
	1 carton (2x200mg/mL) 2 cartons (4x200mg/mL)	<b>Maintenance Dose:</b> Inject 400mg SQ every 4 weeks Inject 200mg SQ every 2 weeks Inject 400mg SQ every other week ( <b>plaque psoriasis only</b> ) Inject 200mg SQ every other week	
<b>COSENTYX®</b> <i>*Pediatrics (age 6 &amp; older)</i>	4 cartons (4x75mg/0.5ml) PFS 4 cartons (4x150mg/ml) PFS 4 cartons (4x150mg/ml) PEN	<b>Starter Dose:</b> <b>Weight &lt; 50kg:</b> Inject 75mg SQ at weeks 0, 1, 2, and 3 <b>Weight ≥ 50kg:</b> Inject 150mg SQ at weeks 0, 1, 2, and 3	<b>No Refills</b>
	1 carton (1x75mg/0.5ml) PFS 1 carton (1x150mg/ml) PFS 1 carton (1x150mg/ml) PEN	<b>Maintenance Dose:</b> <b>Weight &lt; 50kg:</b> Inject 75mg SQ every 4 weeks beginning on Day 29 <b>Weight ≥ 50kg:</b> Inject 150mg SQ every 4 weeks beginning on Day 29	
<b>COSENTYX®</b> <i>*Adults</i> PFS Sensoready® Pen	4 cartons (8x150mg/mL) 4 cartons (4x150mg/mL)	<b>Starter Dose:</b> Inject 300 mg SQ at weeks 0, 1, 2, and 3 <b>Starter Dose:</b> Inject 150 mg SQ at weeks 0, 1, 2, and 3	<b>No Refills</b>
	1 carton (2x150mg/mL) 1 carton (1x150mg/mL)	<b>Maintenance Dose:</b> Inject 300 mg SQ every 4 weeks beginning on Day 29 <b>Maintenance Dose:</b> Inject 150 mg SQ every 4 weeks beginning on Day 29	
<b>DUPIXENT®</b> <i>*Pediatrics (age 6 months to 5 years)</i>	1 carton (2x200mg/1.14mL) 1 carton (2x300mg/2mL)	<b>Weight 5-14kg:</b> Inject 200mg SQ every 4 weeks <b>Weight 15-29kg:</b> Inject 300mg SQ every 4 weeks	
<b>DUPIXENT®</b> <i>*Pediatrics (age 6 &amp; older)</i> PFS Pen <i>*Dupixent pens only for use in adolescents aged 12 or older</i>	1 carton (2x200mg/1.14mL) 1 carton (2x300mg/2mL)	<b>Starter Dose:</b> <b>Weight 15-29kg:</b> Inject 600mg at week 0. Begin maintenance dose at week 4 <b>Weight 30-59kg:</b> Inject 400mg SQ at week 0. Begin maintenance dose at week 2 <b>Weight ≥ 60kg:</b> Inject 600mg SQ at week 0. Begin maintenance dose at week 2	<b>No Refills</b>
	1 carton (2x200mg/1.14mL) 1 carton (2x300mg/2mL)	<b>Maintenance Dose:</b> <b>Weight 15-29kg:</b> Inject 300mg SQ every 4 weeks <b>Weight 30-59kg:</b> Inject 200mg SQ every 2 weeks <b>Weight ≥ 60kg:</b> Inject 300mg SQ every 2 weeks	
<b>DUPIXENT®</b> <i>*Adults</i> PFS Pen	1 carton (2x300mg/2mL)	<b>Starter Dose:</b> Inject 600mg SQ at week 0. Begin maintenance dose at week 2	<b>No Refills</b>
	1 carton (2x300mg/2mL)	<b>Maintenance Dose:</b> Inject 300mg SQ every 2 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