

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:			Practice Name / Collaborating 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: <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)		<input type="radio"/> Basal cell carcinoma (C44._____)	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"/> CIMZIA® <input type="radio"/> PFS <input type="radio"/> Vials	<input type="radio"/> 1 starter kit (6x200mg/mL)	<input type="radio"/> Starter Dose: Inject 400 mg SQ at weeks 0, 2 and 4	No Refills
	<input type="radio"/> 1 carton (2x200mg/mL) <input type="radio"/> 2 cartons (4x200mg/mL)	Maintenance Dose: <input type="radio"/> Inject 400mg SQ every 4 weeks <input type="radio"/> Inject 200mg SQ every 2 weeks <input type="radio"/> Inject 400mg SQ every other week (plaque psoriasis only) <input type="radio"/> Inject 200mg SQ every other week	
<input type="radio"/> COSENTYX® <input type="radio"/> PFS <input type="radio"/> Sensoready® Pen	<input type="radio"/> 4 cartons (8x150mg/mL) <input type="radio"/> 4 cartons (4x150mg/mL)	<input type="radio"/> Starter Dose: Inject 300 mg SQ at weeks 0, 1, 2, and 3 <input type="radio"/> Starter Dose: Inject 150 mg SQ at weeks 0, 1, 2, and 3	No Refills
	<input type="radio"/> 1 carton (2x150mg/mL) <input type="radio"/> 1 carton (1x150mg/mL)	<input type="radio"/> Maintenance Dose: Inject 300 mg SQ every 4 weeks beginning on Day 29 <input type="radio"/> Maintenance Dose: Inject 150 mg SQ every 4 weeks beginning on Day 29	
<input type="radio"/> DUPIXENT® <i>*Pediatrics (age 6 & older)</i>	<input type="radio"/> 1 carton (2x200mg/1.14mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PEN <i>*Dupixent pens only for use in adolescents aged 12 or older</i>	Starter Dose: <input type="radio"/> Weight 15-29kg: Inject 600mg SQ at week 0. Begin maintenance dose at week 4 <input type="radio"/> Weight 30-59kg: Inject 400mg SQ at week 0. Begin maintenance dose at week 2 <input type="radio"/> Weight ≥ 60kg: Inject 600mg SQ at week 0. Begin maintenance dose at week 2	No Refills
	<input type="radio"/> 1 carton (2x200mg/1.14mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PEN <i>*Dupixent pens only for use in adolescents aged 12 or older</i>	Maintenance Dose: <input type="radio"/> Weight 15-29kg: Inject 300mg SQ every 4 weeks <input type="radio"/> Weight 30-59kg: Inject 200mg SQ every 2 weeks <input type="radio"/> Weight ≥ 60kg: Inject 300mg SQ every 2 weeks	
<input type="radio"/> DUPIXENT® *Adults	<input type="radio"/> 1 carton (2x300mg/2mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PEN	<input type="radio"/> Starter Dose: Inject 600mg SQ at week 0. Begin maintenance dose at week 2	No Refills
	<input type="radio"/> 1 carton (2x300mg/2mL) PFS <input type="radio"/> 1 carton (2x300mg/2mL) PEN	<input type="radio"/> Maintenance Dose: Inject 300mg SQ every 2 weeks	
<input type="radio"/> ENBREL® <input type="radio"/> Mini <input type="radio"/> PFS <input type="radio"/> SureClick <input type="radio"/> Vial	<input type="radio"/> 6 cartons (24x50mg/mL)	<input type="radio"/> Starter Dose: Inject 50 mg SQ twice a week (72-96 hours apart) x 3 months	No Refills
	<input type="radio"/> 1 carton (4x50mg/mL)	<input type="radio"/> Maintenance Dose: Inject 50 mg SQ every week	
	<input type="radio"/> PFS: 1 carton (4x25mg/0.5mL) <input type="radio"/> Vial: 1 carton (4x25mg/mL)	<input type="radio"/> Pediatric Dose: < 63 kg (138 lbs) Inject _____ mg (0.8mg/kg) SQ once a week <input type="radio"/> Pediatric Dose: > 63 kg (138 lbs or more) Inject 50 mg SQ once a week	

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.