meijer specialty pharmacy

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Dermatology (E-R)

Enbrel®, Humira®, Ilumya™, Odomzo®, Olumiant®,Orencia®, Otezla®, Rinvoq™

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 **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: ◯ 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 **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
◯ **ENBREL®**	◯ Mini™ ◯ PFS ◯ SureClick® ◯ Vial	◯ 6 cartons (24x50mg/mL)	◯ **Starter Dose:** Inject 50 mg SQ twice a week (72-96 hours apart) x 3 months	**No Refills**
		◯ 1 carton (4x50mg/mL)	◯ **Maintenance Dose:** Inject 50 mg SQ every week	
		◯ **PFS:** 1 carton (4x25mg/0.5mL) ◯ **Vial:** 1 carton (4x25mg/mL)	◯ **Pediatric Dose:** < 63 kg (138 lbs) Inject _____ mg (0.8mg/kg) SQ once a week ◯ **Pediatric Dose:** > 63 kg (138 lbs or more) Inject 50 mg SQ once a week	
◯ **HUMIRA®** (Plaque Psoriasis)	◯ Pens ◯ PFS	**Pens Only:** ◯ Citrate-Free Starter Kit (1x80mg/0.8ml, 2x40mg/0.4ml)	◯ **Starter Dose:** Inject 80 mg SQ Day 1, then 40mg on day 8, then 1 pen every 2 weeks	**No Refills**
		Citrate Free: ◯ 1 carton (2x40mg/0.4ml)	◯ **Maintenance Dose:** Inject 40 mg SQ every 2 weeks	
◯ **HUMIRA®** (Hidradenitis Suppurativa)	◯ Pens ◯ PFS	**Pens Only:** ◯ Citrate-Free Starter Kit	**Starter Dose:** ◯ **Adolescents weighing 30-59kg:** Inject 80mg SQ on day 1, 40mg on day 8 and 40mg on day 22 ◯ **Adolescents weighing ≥ 60kg and adults:** Inject 160mg SQ day 1 (or 80mg SQ on day 1 and day 2); then 80mg on day 15; then begin maintenance dosing on day 29	**No Refills**
		Citrate Free: ◯ 2 cartons (4x40mg/0.4ml) ◯ 1 carton (2x80mg/0.8ml) PEN ONLY	**Maintenance Dose:** ◯ **Adolescents weighing 30-59kg:** Inject 40mg SQ every other week ◯ **Adolescents weighing ≥ 60kg and adults:** Inject 40mg SQ every week ◯ **Adolescents weighing ≥ 60kg and adults:** Inject 80mg SQ every other week	
◯ **ILUMYA™**		◯ 1 carton (1x100mg/mL PFS)	◯ **Starter Dose:** Inject 100mg SQ at week 0. Start maintenance dose at week 4	**No Refills**
			◯ **Maintenance Dose:** Inject 100mg SQ every 12 weeks	
◯ **ODOMZO®**		◯ 200 mg capsule (30 capsules)	◯ Take 1 capsule (200 mg) by mouth once daily on an empty stomach, at least 1 hour before or 2 hours after a meal	
◯ **OLUMIANT®**		◯ 2mg tablets (30 day supply)	◯ Take 1 tablet by mouth once daily ◯ Take 2 tablets by mouth once daily	
◯ **ORENCIA®**	◯ Clickject ◯ PFS	◯ 1 carton (4x125mg/ml)	◯ **Maintenance Dose:** Inject 125 mg SQ once every week	
◯ **OTEZLA®**		◯ 30 mg tablet (55 tabs for 28 Day Starter Pack)	◯ **Starter Dose:** Take as directed per package instructions	**No Refills**
		◯ 30 mg tablet (60 tablets)	◯ **Maintenance Dose:** Take 1 tablet by mouth twice daily	
◯ **RINVOQ™**		◯ 15mg tablet (30 tablets) ◯ 30mg tablet (30 tablets)	◯ Take one tablet by mouth once daily	

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.