

Prescriber Information		Ship Meds to: <input type="radio"/> Patient's Home <input type="radio"/> Prescriber's Office	
Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA <input type="radio"/> 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: <input type="radio"/> M <input type="radio"/> 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:	Crohn's Disease: <input type="radio"/> K50.0 (Crohn's of the Small Intestine) <input type="radio"/> K50.1 (Crohn's of the Large Intestine) <input type="radio"/> K50.8 (Crohn's of Both Intestines) <input type="radio"/> K50.9 (Crohn's, Unspecified)		
Ulcerative Colitis: <input type="radio"/> K51.0 (Ulcerative Pancolitis) <input type="radio"/> K51.2 (Ulcerative Procolitis) <input type="radio"/> K51.3 (Ulcerative Rectosigmoiditis) <input type="radio"/> K51.5 (Left Sided Colitis) <input type="radio"/> K51.8 (Other Ulcerative Colitis)			
<input type="radio"/> K51.9 (Ulcerative Colitis, Unspecified) <input type="radio"/> K58.0 (Irritable Bowel Syndrome with Diarrhea) <input type="radio"/> Other:			
Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? <input type="radio"/> Yes <input type="radio"/> No (provide information below)	
Prior Therapy		Reason for Discontinuation of Therapy	

Prescription Information			
Medication	Quantity/Strength	Sig	Refills
<input type="radio"/> SIMPONI [®] <input type="radio"/> SmartJect <input type="radio"/> PFS	<input type="radio"/> 1 carton (1x50mg/0.5ml PFS) <input type="radio"/> 1 carton (1x100mg/ml PFS) <input type="radio"/> 1 carton (1x50mg/0.5ml Autoinjector) <input type="radio"/> 1 carton (1x100mg/ml Autoinjector)	<input type="radio"/> Starter Dose: Inject 200 mg SQ at week 0; then 100 mg at week 2 <input type="radio"/> Maintenance Dose: Inject 100mg SQ every 4 weeks, starting at week 6	
<input type="radio"/> STELARA [®]	<input type="radio"/> 1 carton (1x45mg/0.5ml PFS) <input type="radio"/> 1 carton (1x90mg/ml PFS)	Maintenance Dose: <input type="radio"/> Inject 0.5ml (45mg) SQ 8 weeks after infusion, then every 8 weeks thereafter <input type="radio"/> Inject 1ml (90mg) SQ 8 weeks after infusion, then every 8 weeks thereafter	
<input type="radio"/> XELJANZ [®]	<input type="radio"/> 10mg tablets (quantity QS for length of starter dose therapy, in multiples of 60 tablets) <input type="radio"/> 5mg tablets (30 day supply) <input type="radio"/> 10mg tablets (30 day supply)	<input type="radio"/> Starter Dose: Take 10mg by mouth twice daily for ____ weeks <input type="radio"/> Maintenance Dose: Take 1 tablet by mouth two times a day	No Refills
<input type="radio"/> XELJANZ XR	<input type="radio"/> 22mg tablets (quantity QS for length of starter dose therapy, in multiples of 30 tablets) <input type="radio"/> 11mg tablets (30 day supply)	<input type="radio"/> Starter Dose: Take 22mg by mouth once daily for ____ weeks <input type="radio"/> Maintenance Dose: Take 11mg by mouth once daily	No Refills
<input type="radio"/> XIFAXAN [®]	<input type="radio"/> 200mg tablet <input type="radio"/> 550mg tablet	<input type="radio"/> Take 1 tablet by mouth 2 times a day for ____ days <input type="radio"/> Take 1 tablet by mouth 3 times a day for ____ days	

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.