

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

Diagnosis M32.9 Active Systemic Lupus Erythematosus M45.9 Ankylosing Spondylitis M08.0 Juvenile Idiopathic Arthritis L40.59 Psoriatic Arthritis L40.54 Psoriatic Juvenile Arthritis

M06.9 Rheumatoid Arthritis M46.8 Non-Radiographic Axial Spondyloarthritis Other: _____

Date of Diagnosis: / / Date of Negative TB Test: / / Any prior treatment? Y N If Yes, provide information below

Prior Therapy: _____ Reason for Discontinuation of Therapy: _____ Approximate Start Date: _____ Approximate End Date: _____

Comorbidities: _____ Concomitant Medications: _____

Allergies: NKDA Other: _____ **Treatment Arrangements** Ship Meds: Home Prescribers Office Start Date: / /

Prescription Information

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> KEZVARA® <input type="radio"/> PFS <input type="radio"/> Pen	<input type="radio"/> 1 carton (2x200mg/1.14ml) <input type="radio"/> 1 carton (2x150mg/1.14ml)	<input type="radio"/> Inject 200mg SQ every 2 weeks <input type="radio"/> Inject 150mg SQ every 2 weeks	
<input type="radio"/> OLUMIANT®	<input type="radio"/> 2mg tablet (30 day supply)	<input type="radio"/> Take 1 tablet by mouth once daily	
<input type="radio"/> ORENCIA® <input type="radio"/> Clickject® <input type="radio"/> PFS	<input type="radio"/> 1 carton (4x125mg/ml)	<input type="radio"/> Maintenance Dose: Inject 125 mg SQ once every week	
<input type="radio"/> OTEZLA®	<input type="radio"/> Starter Pack 10/20/30mg tablets (55 tabs for 28 days)	<input type="radio"/> Starter Dose: Take as directed per package instructions	No Refills
	<input type="radio"/> 30 mg tablet (60 tablets)	<input type="radio"/> Maintenance Dose: Take 1 tablet (30mg) by mouth twice daily	
<input type="radio"/> OTREXUP™	<input type="radio"/> 1 carton (4x10mg/0.4ml)	<input type="radio"/> Inject ____mg SQ every week	
	<input type="radio"/> 1 carton (4x12.5mg/0.4ml)		
	<input type="radio"/> 1 carton (4x15mg/0.4ml)		
	<input type="radio"/> 1 carton (4x17.5mg/0.4ml)		
<input type="radio"/> RASUVO® <input type="radio"/> Auto-Injector	<input type="radio"/> 4x7.5mg/0.15ml	<input type="radio"/> Inject ____mg SQ every week	
	<input type="radio"/> 4x10mg/0.20ml		
	<input type="radio"/> 4x12.5mg/0.25ml		
	<input type="radio"/> 4x15mg/0.30ml		
	<input type="radio"/> 4x17.5mg/0.35ml		
<input type="radio"/> RINVOQ™	<input type="radio"/> 15mg tablet (30 day supply)	<input type="radio"/> Take 1 tablet by mouth once daily	
<input type="radio"/> SIMPONI® <input type="radio"/> SmartJect® <input type="radio"/> PFS	<input type="radio"/> 1 carton (1x50mg/0.5ml)	<input type="radio"/> Inject 50 mg SQ once every month	
<input type="radio"/> STELARA® PFS Patient eligible for self-injection? <input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> 1 carton (1x45mg/0.5ml) <input type="radio"/> 1 carton (1x90mg/ml)	<input type="radio"/> Starter Dose: Inject 45 mg SQ on day 1 (<100kg)	No Refills
		<input type="radio"/> Starter Dose: Inject 90 mg SQ on day 1 (>100kg)	
		<input type="radio"/> Maintenance Dose: Inject 45 mg SQ on day 29 and every 12 weeks thereafter (<100kg)	
		<input type="radio"/> Maintenance Dose: Inject 90 mg SQ on day 29 and every 12 weeks thereafter (>100kg)	

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.