meijer specialty pharmacy

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Gastroenterology - Other Therapies

Send updates to: ◯ Fax: _____ ◯ Email: _____ ◯ Text: _____

Physician Information

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	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: ◯ M ◯ 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:** ◯ K50.0___(Crohn's of the **Small** Intestine) ◯ K50.1___(Crohn's of the **Large** Intestine) ◯ K50.8___(Crohn's of **Both** Intestines) ◯ K50.9___(Crohn's, Unspecified)

Ulcerative Colitis: ◯ K51.0___(Ulcerative Pancolitis) ◯ K51.2___(Ulcerative Procolitis) ◯ K51.3___(Ulcerative Rectosigmoiditis) ◯ K51.5___(Left Sided Colitis) ◯ K51.8___(Other Ulcerative Colitis)

◯ K51.9___ (Ulcerative Colitis, Unspecified) ◯ K58.0___ (Irritable Bowel Syndrome with Diarrhea) ◯ Other:

Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? ◯ Yes ◯ No (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
◯ **CANASA**®	◯ Box of 30 ◯ Box of 42	◯ 1000mg rectal suppository inserted rectally once daily at bedtime		
◯ **RELISTOR**® ◯ PFS ◯ Vial	◯ 8mg (Qty 7) ◯ 12mg (Qty 7) ◯ 12mg (Qty 1)	◯ Inject 12mg SQ once daily ◯ Inject _____ mg SQ every other day	28 Day Supply	
◯ **UCERIS**®	◯ 9mg tablet	◯ Take once daily by mouth for up to 8 weeks	30 Day Supply	
◯ **UCERIS**® **RECTAL FOAM**	◯ 2mg (14 doses/package)	◯ Administer 1 metered dose (2mg) rectally twice daily for 2 weeks, then 1 metered dose (2mg) rectally once daily for 4 weeks.	28 Day Supply	
◯ **XIFAXAN**®	◯ 200mg tablet ◯ 550mg tablet	◯ Take 1 tablet by mouth 3 times a day for _____ days		
◯ Other:				

Injection Training

◯ Patient received injection training	◯ Prescriber's office to provide injection training	◯ Meijer to coordinate injection training	◯ Patient to receive injection training at Meijer

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.

Physician Signature: Date	Physician Signature: Date
Substitution Permitted	Dispense as Written