meijer specialty pharmacy

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Gastroenterology Pediatric

Physician Information

Send updates to: ○ Fax: ______ ○ Email: ______ ○ Text: ______

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
○ **HUMIRA® PEDIATRIC**	○ 1 carton (3x40 mg/0.8mL PFS) ○ 1 carton (6x40 mg/0.8mL PFS) ○ 1 carton (2 x 20 mg/0.4mL PFS) ○ 1 carton (2 x 40 mg/0.8mL PFS) ○ 1 carton (2x40mg/0.8ml PENS)	**Starter Dose:** ○ Inject 80mg SQ on Day 1, then 40mg on Day 15 (17 to < 40 kg or 37 to < 88lbs) ○ Inject 80 mg SQ on Day 1 and Day 2; then 80 mg on Day 15 (≥ 40 kg or ≥ 88lbs) ○ Inject 160 mg SQ Day 1; then 80 mg on Day 15 (≥ 40 kg or ≥ 88lbs) **Maintenance Dose:** ○ Starting on Day 29, inject 20 mg SQ every other week (17 to < 40 kg or 37 to < 88lbs) ○ Starting on Day 29, inject 40 mg SQ every other week (≥ 40 kg or ≥ 88lbs)		
○ **REMICADE®**	○ Exact Dose ○ Round dose up/down to nearest 100mg	○ Infuse _____ mg in 250NS over 2hrs at week 0, 2, 6 and then every 8 weeks. ○ Other Regimen: **Titrated infusion rate will be used unless otherwise noted: 10ml/hr x 15min; 20ml/hr x 15min; 40ml/hr x 15min; 80ml/hr x 15min; 150ml/hr x 30 min*		
○ Other:				
○ 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

MSPGIPediatric012517