meijer specialty pharmacy

P: 1-855-263-4537 • F: 1-877-222-5036
www.MeijerSpecialtyPharmacy.com

Rheumatology (A-O)

Actemra®, Benlysta®, Cimzia®, Cosentyx®, Enbrel®, Humira®, Kevzara®, Orencia®, Otezla®, Otrexup®

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		

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 ◯ H20 Iridocyclitis (Uveitis) ◯ Other:

Date of Diagnosis: / / | Date of Negative TB Test: / / | Any prior treatment? ◯ Yes ◯ No (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 ◯ Doctor's Office | Start Date: / / | *Counseling and education provided by Meijer's Clinical Team

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **ACTEMRA®** ◯ PFS	◯ 2 cartons (2x162mg/0.9ml) ◯ 4 cartons (4x162mg/0.9ml)	◯ Inject 162 mg SQ every other week (<100kg) ◯ Inject 162 mg SQ every week (>100kg)	
◯ **BENLYSTA®** ◯ Vial ◯ PFS ◯ Pen	◯ Number of 120mg/5 ml vials _____ ◯ Number of 400mg/20 ml vials _____ ◯ 1 carton (4x200mg/ml)	◯ **Starter Dose:** Infuse _____ mg IV over 1 hour at weeks 0, 2, and 4	**No Refills**
		◯ **Maintenance Dose:** Infuse _____ IV over 1 hour once every 4 weeks ◯ **Maintenance Dose:** Administer 200mg SQ once every week	
◯ **CIMZIA®** ◯ PFS ◯ Vial	◯ **PFS Only:** Starter Kit (6x200mg/ml)	◯ **Starter Dose:** Inject 400 mg SQ at weeks 0, 2, and 4	**No Refills**
	◯ 1 carton (2x200 mg/ml)	◯ **Maintenance Dose:** Inject 400 mg SQ every 4 weeks ◯ **Maintenance Dose:** Inject 200 mg SQ every 2 weeks	
◯ **COSENTYX®** ◯ PFS ◯ Sensoready Pen®	◯ 4 cartons (8x150mg/mL) ◯ 4 cartons (4x150mg/mL)	◯ **Starter Dose:** Inject 300 mg SQ at weeks 0, 1, 2, 3 ◯ **Starter Dose:** Inject 150 mg SQ at weeks 0, 1, 2, 3	**No Refills**
	◯ 1 carton (2x150mg/mL) ◯ 1 carton (1x150mg/mL)	◯ **Maintenance Dose:** Inject 300 mg SQ every 4 weeks beginning on Day 29 ◯ **Maintenance Dose:** Inject 150 mg SQ every 4 weeks beginning on Day 29	
◯ **ENBREL®** ◯ SureClick® ◯ PFS ◯ Vial	◯ 1 carton (4 x 50mg/ml) ◯ Other:	◯ Inject 50 mg SQ every week ◯ Other Regimen:	
◯ **HUMIRA®** ◯ PFS ◯ Pen	◯ 1 carton (2x40mg/0.8ml) ◯ 2 cartons (4x40mg/0.8ml)	◯ Inject 40 mg SQ every 14 days ◯ Inject 40 mg SQ every 7 days	
◯ **HUMIRA®** (Uveitis) ◯ PFS ◯ Pen	◯ **Pens Only:** Starter Kit (4x40mg/0.8ml)	◯ Inject 2 pens (80mg) SQ on Day 1, then 1 pen (40mg) on Day 8, then 1 pen every 2 weeks	**No Refills**
	◯ 1 carton (2x40mg/0.8 ml)	◯ Inject 40mg SQ every 14 days	
◯ **KEVZARA®** ◯ PFS	◯ 1 carton (2x200mg/1.14ml) ◯ 1 carton (2x150/1.14ml)	◯ Inject 200mg SQ every 2 weeks ◯ Inject 150mg SQ every 2 weeks	
◯ **ORENCIA®** ◯ Clickject® ◯ PFS ◯ Vial	◯ **Vials:** QS for starter dose	◯ **Starter Dose:** Infuse _____mg IV in 100ml NS over 30 minutes at weeks 0 and 2	**No Refills**
	◯ **Vials:** QS for maintenance dose ◯ **Pens/PFS:** 1 carton (4x125mg/ml)	◯ **Maintenance Dose**: Inject 125 mg SQ once every week ◯ **Maintenance Dose:** Infuse _____mg IV in 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter	
◯ **OTEZLA®** ◯ Tablet	◯ 10/20/30mg tablets (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 (30mg) by mouth twice daily	
◯ **OTREXUP™** ◯ Auto-injector	◯ 10mg/0/4ml ◯ 20mg/0.4ml ◯ 12.5mg/0.4ml ◯ 22.5mg/0/0.4ml ◯ 15mg/0.4ml ◯ 25mg/0.4ml ◯ 17.5mg/0.4ml	◯ Inject _____mg SQ every week	

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