℞ meijer specialty pharmacy

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

Rheumatology (P-Z)

Rasuvo®, Remicade®, Rituxan®, Simponi®, Simponi Aria®, Stelara®, Xeljanz®, Xeljanz XR®, Other

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 Juvenille ◯ 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
◯ **RASUVO®** ◯ Auto-injector	◯ 7.5 mg/0.15ml ◯ 20mg/0.40mL ◯ 10mg/0.20mL ◯ 22.5mg/0.45mL ◯ 12.5mg/0.25mL ◯ 25mg/0.50mL ◯ 15mg/0.30mL ◯ 27.5mg/0.55mL ◯ 17.5mg/0.35mL ◯ 30mg/0.60mL	◯ Inject _____mg SQ every week	
◯ **REMICADE®** ◯ Vial	◯ Number of 100mg vials _____x3	◯ **Starter Dose:** Infuse _____mg IV over 2 hours at weeks 0, 2, and 6	No Refills
	◯ Number of 100mg vials _____	◯ **Maintenance Dose:** Infuse _____mg IV over 2 hours once every _____ weeks	
◯ **RITUXAN®** ◯ Vial	◯ Number of 500 mg vials _____	◯ Infuse 1000mg IV over 4-6 hours on day 1 and 15 and every_____ weeks thereafter	
◯ **SIMPONI®** ◯ SmartJect® ◯ PFS	◯ 1 carton (1x50mg/0.5ml)	◯ Inject 50 mg SQ once every month	
◯ **SIMPONI ARIA™** ◯ Vial	◯ QS for starter dose	◯ **Starter Dose:** Infuse _____ mg IV over 30 minutes at weeks 0 and 4	No Refills
	◯ QS for maintenance dose	◯ **Maintenance Dose:** Infuse _____ mg IV over 30 minutes once every 8 weeks	
◯ **STELARA®** ◯ PFS Patient eligible for self-injection? ◯ Yes ◯ No	◯ 1 carton (1x45mg/0.5ml) ◯ 1 carton (1x90mg/ml)	◯ **Starter Dose:** Inject 45 mg SQ on day 1 (<100kg) ◯ **Starter Dose:** Inject 90 mg SQ on day 1 (>100kg)	No Refills
		◯ **Maintenance Dose:** Inject 45 mg SQ on day 29 and every 12 weeks thereafter (<100kg) ◯ **Maintenance Dose:** Inject 90 mg SQ on day 29 and every 12 weeks thereafter (>100kg)	
◯ **XELJANZ®** ◯ Tablet	◯ 5 mg tablets (60 tablets)	◯ Take 1 tablet (5 mg) by mouth twice a day	
◯ **XELJANZ® XR** ◯ Tablet	◯ 11 mg tablets (30 tablets)	◯ Take 1 tablet (11mg) by mouth every day	
◯ 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