

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
Address:			City:			State:		Zip:		
Home Phone:		Work/Cell:		HIPAA 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										
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: / /			Prior Treatment? Y N (Provide Information Below)			
Prior Therapy:				Reason for Discontinuation of Therapy:				Approx. Start Date: / /		
								Approx. End Date: / /		
Prescription Information										
Medication	Quantity/Dose			Sig			Refills			
SIMPONI® Smartlect PFS	3 cartons (50mg/0.5ml) 3 cartons (100mg/ml)			Starter Dose: Adults & pediatric patients ≥40kg: Inject 200mg SQ at week 0, then 100mg at week 2 Pediatric patients 15-39kg: Inject 100mg SQ at week 0, then 50mg at week 2			No Refills			
	1 carton (50mg/0.5ml) 1 carton (100mg/ml)			Maintenance Dose: Adults & pediatric patients ≥40kg: Pediatric patients 15-39kg: Inject 50mg SQ every 4 weeks, starting at week 6						
SKYRIZI®	1 cartridge (360mg/2.4ml) with on-body injector 1 cartridge (180mg/1.2ml) with on-body injector			Maintenance Dose: Inject 360mg SQ beginning at week 12, and every 8 weeks thereafter Inject 180mg SQ beginning at week 12, and every 8 weeks thereafter						
STELARA®	1 carton (1x90mg/ml PFS)			Maintenance Dose: Inject 1ml (90mg) SQ 8 weeks after infusion, then every 8 weeks thereafter						
TREMFYA® PFS Pen	CD/UC Induction Pack (2x200mg/ml PENS)			CD/UC Starter Dose: Inject 400mg SQ at weeks 0, 4 and 8			2 Refills			
	1 carton (1x100mg/ml) 1 carton (1x200mg/ml)			Maintenance Dose: Inject 100mg SQ at week 16 and every 8 weeks thereafter Inject 200mg SQ at week 12 and every 4 weeks thereafter						
VELSIPITY™	2mg tablets (30 day supply)			Take 1 tablet by mouth once daily						
XELJANZ®	10mg tablets (quantity QS for length of starter dose therapy, in multiples of 60 tablets)			Starter Dose: Take 10mg by mouth twice daily for ____ weeks			No Refills			
	5mg tablets (30 day supply) 10mg tablets (30 day supply)			Maintenance Dose: Take 1 tablet by mouth two times a day						
XELJANZ® XR	22mg tablets (quantity QS for length of starter dose therapy, in multiples of 30 tablets)			Starter Dose: Take 22mg by mouth once daily for ____ weeks			No Refills			
	11mg tablets (30 day supply) 22mg tablets (30 day supply)			Maintenance Dose: Take 1 tablet by mouth once daily						
XIFAXAN®	200mg tablet 550mg tablet			Take 1 tablet by mouth 2 times a day for ____ days Take 1 tablet by mouth 3 times a day for ____ days						
ZEPOSIA®	Starter Pack (7 day supply) Starter Kit (37 day supply)			Take 0.23mg by mouth daily on days 1-4, then 0.46mg daily on days 5-7, then 0.92mg daily thereafter						
	0.92mg capsules (30 day supply)			Maintenance Dose: Take 1 capsule by mouth daily						
ZYMFENTRA™ (infliximab-dyyb) PFS Pen	1 carton (2x120mg/ml)			Maintenance Dose: Inject 120mg SQ every 2 weeks, starting at week 10						
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.					