

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

Patient 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

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 M45.A ____ Non-Radiographic Axial Spondyloarthritis Other:					
Date Diagnosis: / /	Date of Neg. TB Test: / /	Any prior treatment? Y N			
Notes for Pharmacy:					

Prescription Information

Medication	Quantity/Dose	Sig	Refills
RASUVO® Auto-Injector	4x7.5mg/0.15ml 4x10mg/0.20ml 4x12.5mg/0.25ml 4x15mg/0.30ml 4x17.5mg/0.35ml 4x20mg/0.4ml 4x22.5mg/0.45ml 4x25mg/0.50ml 4x30mg/0.60ml	Inject ____ mg SQ every week	
RINVOQ™ *Adults	15mg tablet (30 day supply)	Take 1 tablet by mouth once daily	
RINVOQ™ *Pediatrics	1mg/ml oral solution (quantity QS for 30 day supply in multiples of 180ml) 15mg tablet (30 day supply)	Weight 10-19kg: Take 3mg (3ml oral solution) by mouth two times daily Weight 20-29kg: Take 4mg (4ml oral solution) by mouth two times daily Weight ≥ 30kg: Take 6mg (6ml oral solution) by mouth twice daily Take 15mg (one 15mg tablet) by mouth once daily	
SIMPONI® SmartJect® PFS	1 carton (1x50mg/0.5ml)	Inject 50 mg SQ once every month	
SKYRIZI™ PFS Pen	1 carton (150mg/ml)	Starter Dose: Inject 150mg SQ at weeks 0 and 4	1 Refill
	1 carton (150mg/ml)	Maintenance Dose: Inject 150mg SQ every 12 weeks	
STELARA® *Adults	1 carton (1x45mg/0.5ml) 1 carton (1x90mg/ml)	Starter Dose: Weight < 100kg: Inject 45mg SQ at weeks 0 and 4 Weight > 100kg: Inject 90mg SQ at weeks 0 and 4	1 Refill
		Maintenance Dose: Weight < 100kg: Inject 45mg SQ every 12 weeks Weight > 100kg: Inject 90mg SQ every 12 weeks	
STELARA® *Pediatrics	1 carton (1x45mg/0.5mL) PFS 1 carton (1x90mg/mL) PFS 1 vial (45mg/0.5mL)	Starter Dose: Weight <60kg: Inject ____mg (0.75mg/kg) SQ at weeks 0 and 4 Weight 60-100kg: Inject 45mg SQ at weeks 0 and 4 Weight > 100kg: Inject 90mg SQ at weeks 0 and 4	1 Refill
	1 carton (1x45mg/0.5mL) PFS 1 carton (1x90mg/mL) PFS 1 vial (45mg/0.5mL)	Maintenance Dose: Weight < 60kg: Inject ____mg (0.75mg/kg) SQ every 12 weeks Weight 60-100kg: Inject 45mg SQ every 12 weeks Weight > 100kg: Inject 90mg SQ every 12 weeks	

Injection Training

Patient received injection training	Prescriber's office to provide injection training	Meijer to coordinate injection training
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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
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Substitution Permitted

Dispense as Written
 If brand is required, please write "DAW" in the box to the right.

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