


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:
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: Alopecia areata (L63) Psoriasis Vulgaris (L40.0) Other Psoriasis (L40.8) Psoriasis unspecified (L40.9) Psoriatic Arthritis (L40.5)									
Hidradenitis Suppurativa (L73.2) Chronic Urticaria (L50.8) Atopic Dermatitis (L20.9) Basal cell carcinoma (C44.) Other:									
TB/PDD Test Given: Y N		Date of Neg. Test: / /			HBV Positive? Y N If Yes, is patient currently treated? Y N				
Prior Treatment? Y N (Provide Information Below)		BSA Affected (%):		Affected Areas: Palms Soles Head Neck Genitalia Other:					
Prior Therapy:				Reason for Discontinuation of Therapy:					Approx. Start Date: / /
									Approx. End Date: / /
Comorbidities:				Concomitant Medications:					
Prescription Information									
Medication		Quantity/Dose		Sig				Refills	
ENBREL®	Mini™	6 cartons (24x50mg/mL)		Starter Dose: Inject 50 mg SQ twice a week (72-96 hours apart) x 3 months				No Refills	
	PFS	1 carton (4x50mg/mL)		Maintenance Dose: Inject 50 mg SQ every week					
	SureClick® Vial	PFS: 1 carton (4x25mg/0.5mL) Vial: 1 carton (4x25mg/mL)		Pediatric Dose: < 63 kg (138 lbs) Inject _____ mg (0.8mg/kg) SQ once a week Pediatric Dose: > 63 kg (138 lbs or more) Inject 50 mg SQ once a week					
HUMIRA®			To prescribe Humira, please use the Humira & Biosimilars Referral form. Scan QR Code or click this link to view Referral Form.						
ILUMYA™	1 carton (1x100mg/mL PFS)		Starter Dose: Inject 100mg SQ at week 0. Start maintenance dose at week 4				No Refills		
			Maintenance Dose: Inject 100mg SQ every 12 weeks						
ODOMZO®	200 mg capsule (30 capsules)		Take 1 capsule (200 mg) by mouth once daily on an empty stomach, at least 1 hour before or 2 hours after a meal						
OLUMIANT®	2mg tablets (30 day supply)		Take 1 tablet by mouth once daily Take 2 tablets by mouth once daily						
ORENCIA® *Adults	Clickject PFS	1 carton (4x125mg/ml)		Maintenance Dose: Inject 125 mg SQ once every week					
ORENCIA® *Pediatrics	1 carton (4x125mg/ml) Clickject® Pen 1 carton (4x125mg/ml) PFS 1 carton (4x87.5mg/0.7ml) 1 carton (4x50mg/0.4ml)		Weight 10-24kg: Inject 50mg SQ once every week Weight 25-49kg: Inject 87.5mg SQ once every week Weight 50kg+: Inject 125mg SQ once every week						
OTEZLA®	30 mg tablet (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 by mouth twice daily						
RINVOQ™	15mg tablet (30 tablets) 30mg tablet (30 tablets)		Take one tablet by mouth once daily						
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	
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Substitution Permitted

Dispense as Written

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