

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 <b>If Yes, list allergies:</b>									
Insurance Information											
Primary Insurance:			Policy ID:		Group #:		BIN:		PCN:		
Policyholder Name:					Policyholder DOB:    /    /						
Dermatology • 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:		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.____)		TB/PDD Test Given:    Y    N		Date of Neg. Test:    /    /		HBV Positive?    Y    N		<b>If Yes, is patent currently treated?    Y    N</b>	
Prior Treatment?    Y    N (Provide Information Below)		BSA Affected (%):		Affected Areas:    Palms    Soles    Head    Neck    Genitalia    Other:							
Gastroenterology • 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:		<b>Crohn's Disease:</b>		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)	
<b>Ulcerative Colitis:</b>		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)			
Rheumatology • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES											
<b>Diagnosis:</b>		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 <b>If Yes, provide information below:</b>							
Prior Therapy											
Prior Therapy:				Reason for Discontinuation of Therapy:				Approx. Start Date:    /    /		Approx. End Date:    /    /	
Comorbidities:				Concomitant Medications:				Allergies:    NKDA    Other:			
Prescription Information											
Medication	Quantity/Dose		Sig						Refills		
<b>BENLYSTA®</b>	Number of 120mg/5ml vials: _____		<b>Starter Dose:</b> Infuse _____mg IV over 1 hour at weeks 0, 2, and 4						<b>No Refills</b>		
	Number of 400mg/20ml vials: _____		<b>Maintenance Dose:</b> Infuse _____mg IV over 1 hour once every 4 weeks								
<b>COSENTYX®</b>	Number of 125mg/5ml vials: _____		<b>Starter Dose:</b> Infuse _____mg at week 0 No starter dose						<b>No Refills</b>		
	Number of 125mg/5ml vials: _____		<b>Maintenance Dose:</b> Infuse _____mg every 4 weeks								
<b>ENTYVIO®</b>	<b>Starter Dose:</b> 2 vials		<b>Starter Dose:</b> Infuse 300mg IV over 30 minutes at weeks 0 and 2						<b>No Refills</b>		
	<b>Maintenance Dose:</b> Number of 300mg vials:		<b>Maintenance Dose:</b> Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6								
<b>OMVOH™</b>	Number of 300mg/15ml vials: _____		<b>Starter Dose:</b> Infuse 300mg at weeks 0, 4 and 8. Begin SQ maintenance dosing at week 12.						<b>No Refills</b>		
<b>ORENCIA®</b>	Number of 250mg vials: _____		<b>Starter Dose:</b> Infuse _____ mg IV in 100ml NS over 30 minutes at weeks 0 and 2						<b>No Refills</b>		
			<b>Maintenance Dose:</b> Infuse _____mg IV in 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter								

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.