

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

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 If Yes, provide information below:			
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
HUMIRA® *Adults	PFS Pen	1 carton (2x40mg/0.4ml) 2 cartons (4x40mg/0.4ml) 1 carton (2x80mg/0.8ml) – PEN ONLY	Inject 40mg SQ every other week Inject 40mg SQ every week Inject 80mg SQ every other week	
HUMIRA® *Pediatrics age 2+	PFS Pen	1 carton (2x10mg/0.1ml) – PFS ONLY 1 carton (2x20mg/0.2ml) – PFS ONLY 1 carton (2x40mg/0.4ml)	Weight 10kg (22lbs) to < 15kg (33lbs): Inject 10mg SQ every other week Weight 15kg (33lbs) to < 30kg (66lbs): Inject 20mg SQ every other week Weight ≥ 30kg (66lbs): Inject 40mg SQ every other week	
		 To prescribe a biosimilar, please use the Humira & Biosimilars Referral Form. Scan QR Code or click this link to view Referral Form.		
ILARIS®		150mg/ml vial (28 day supply)	Inject _____ mg SQ every 4 weeks Other:	
KEVZARA®	PFS Pen	1 carton (2x200mg/1.14ml) 1 carton (2x150mg/1.14ml)	Inject 200mg SQ every 2 weeks Inject 150mg SQ every 2 weeks	
OLUMIANT®		2mg tablet (30 day supply)	Take 1 tablet 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® *Adults		Starter Pack: Immediate Release Extended Release (XR) 30mg IR tablet (60 tablets) 75mg XR tablet (30 tablets)	Starter Dose: Take as directed per package instructions Maintenance Dose: Take 1 tablet by mouth twice daily Take 1 tablet by mouth daily	No Refills
OTEZLA® *Pediatrics		Weight 20-49kg: Pediatric Starter Pack Weight 50kg or more: Adult Immediate Release Starter Pack Adult XR Starter Pack Weight 20-49kg: 20mg tablet (60 tablets) Weight 50kg or more: 30mg IR tablet (60 tablets) 75mg XR tablet (30 tablets)	Starter Dose: Take as directed per package instructions Maintenance Dose: Take 1 tablet by mouth twice daily Take 1 tablet by mouth daily	No Refills
OTREXUP™		1 carton (4x10mg/0.4ml) 1 carton (4x20mg/0.4ml) 1 carton (4x12.5mg/0.4ml) 1 carton (4x22.5mg/0.4ml) 1 carton (4x15mg/0.4ml) 1 carton (4x25mg/0.4ml)	Inject _____mg SQ every week	

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.