

**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:	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	If Yes, is patent 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
<b>SILIQ®</b> <small>*Product is limited to certified prescribers enrolled in Siliq REMS</small>	2 cartons (4x210mg/1.5mL)	<b>Starter Dose:</b> Inject 210 mg SQ at weeks 0, 1, and 2 and then every 2 weeks after	<b>No Refills</b>
	1 carton (2x210mg/1.5mL)	<b>Maintenance Dose:</b> Inject 210 mg SQ once every 2 weeks	
<b>SIMPONI®</b> <small>SmartJect® PFS</small>	1 carton (1x50mg/0.5ml)	Inject 50 mg SQ once a month	
<b>SKYRIZI™</b> <small>PFS Pen</small>	1 carton (150mg/mL)	<b>Starter Dose:</b> Inject 150mg SQ at weeks 0 and 4	<b>1 Refill</b>
	1 carton (150mg/mL)	<b>Maintenance Dose:</b> Inject 150mg SQ every 12 weeks	
<b>SOTYKTU™</b>	6mg tablet (30 day supply)	Take 1 tablet by mouth once daily	
<b>STELARA®</b> <small>Patient eligible for self-injection? Y N</small>	1 carton (1x45mg/0.5mL)	<b>Starter Dose:</b> Inject 45 mg SQ on Day 1 (≤100 kg) <b>Starter Dose:</b> Inject 90 mg SQ on Day 1 (>100 kg)	<b>No Refills</b>
<b>*Adults</b>	1 carton (1x90mg/mL)	<b>Maintenance Dose:</b> Inject 45mg SQ once every 12 weeks beginning on Day 29 (≤100kg) <b>Maintenance Dose:</b> Inject 90mg SQ once every 12 weeks beginning on Day 29 (>100kg)	
<b>STELARA®</b> <small>*Pediatrics</small>	1 carton (1x45mg/0.5mL) PFS 1 carton (1x90mg/mL) PFS 1 vial (45mg/0.5mL)	<b>Starter Dose:</b> Patients <60kg: Inject 0.75mg/kg SQ on day 1 Patients 60kg-100kg: Inject 45mg SQ on day 1 Patients >100kg: Inject 90mg SQ on day 1	<b>No Refills</b>
	1 carton (1x45mg/0.5mL) PFS 1 carton (1x90mg/mL) PFS 1 vial (45mg/0.5mL)	<b>Maintenance Dose:</b> Patients <60kg: Inject 0.75mg/kg SQ once every 12 weeks, starting on day 29 Patients 60kg-100kg: Inject 45mg SQ once every 12 weeks, starting on day 29 Patients >100kg: Inject 90mg SQ once every 12 weeks, starting on day 29	

**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.