

Prescriber Information

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|------------------|--|-----------------------------------|----|--------|----|------|
| 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

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|--------------------|------------|-----------------------|------|------|
| 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 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 |
|--|---|--|-------------------|
| HUMIRA® *Adults PFS Pen | 2 cartons (4x40mg/0.4ml) 3 cartons (6x40mg/0.4ml) 1 carton (2x80mg/0.8ml) AND 1 carton (2x40mg/0.4ml) | Starter Dose: Inject 80mg SQ on day 1. Begin maintenance dosing on day 8. Inject 160mg SQ on day 1, then 80mg on day 15. Begin maintenance dosing on day 29. Inject 80mg SQ on day 1, then 80mg on day 2, then 80mg on day 15. Begin maintenance dosing on day 29. | No Refills |
| | 1 carton (2x40mg/0.4ml) 2 cartons (4x40mg/0.4ml) 1 carton (2x80mg/0.8ml) – PEN ONLY | Maintenance Dose: Inject 40mg SQ every other week Inject 40mg SQ every week Inject 80mg SQ every other week | |
| HUMIRA® *Adolescents age 12+ (HS) PFS Pen | 2 cartons (4x40mg/0.4ml) 3 cartons (6x40mg/0.4ml) 1 carton (2x80mg/0.8ml) AND 1 carton (2x40mg/0.4ml) | Starter Dose: Weight 30kg to < 60kg: Inject 80mg SQ on day 1. Begin maintenance dosing on day 8. Weight 30kg to < 60kg: Inject 160mg SQ on day 1, then 80mg on day 15. Begin maintenance dosing on day 29. Inject 80mg SQ on day 1, then 80mg on day 2, then 80mg on day 15. Begin maintenance dosing on day 29. | No Refills |
| | 1 carton (2x40mg/0.4ml) 2 cartons (4x40mg/0.4ml) 1 carton (2x80mg/0.8ml) – PEN ONLY | Maintenance Dose: Weight 30kg to < 60kg: Inject 40mg SQ every other week Weight 30kg to < 60kg: Inject 40mg SQ every week Inject 80mg 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. | | | |
| 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 | |

Injection Training

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|-------------------------------------|---|---|
| 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 |
|----------------------|------|----------------------|------|

Substitution Permitted

Dispense as Written

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