meijer specialty pharmacy

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◯ New/Changed Dose

Gastroenterology (S-Z)

Simponi®, Skyrizi®, Stelara®, Velsipity™, Xeljanz®, Xeljanz® XR, Xifaxan®, Zeposia®, Zymfentra™

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:

Crohn's Disease: ◯ 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)

Ulcerative Colitis: ◯ 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)**

Prior Therapy:	Reason for Discontinuation of Therapy:	Approx. Start Date: / /
		Approx. End Date: / /

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **SIMPONI®** ◯ SmartJect ◯ PFS	◯ 3 cartons (100mg/ml)	◯ **Starter Dose:** Inject 200mg SQ at week 0; then 100mg at week 2	**No Refills**
	◯ 1 carton (100mg/ml)	◯ **Maintenance Dose:** Inject 100mg SQ every 4 weeks, starting at week 6	
◯ **SKYRIZI®**	◯ 1 cartridge (360mg/2.4ml) with on-body injector ◯ 1 cartridge (180mg/1.2ml) with on-body injector ◯ 1 carton (2x90mg/ml) PFS ◯ 1 carton (4x90mg/ml) PFS	**Maintenance Dose:** ◯ Inject 360mg SQ beginning at week 12, and every 8 weeks thereafter ◯ Inject 180mg SQ beginning at week 12, and every 8 weeks thereafter	
◯ **STELARA®**	◯ 1 carton (1x90mg/ml PFS)	**Maintenance Dose:** ◯ Inject 1ml (90mg) SQ 8 weeks after infusion, then every 8 weeks thereafter	
◯ **VELSIPITY™**	◯ 2mg tablets (30 day supply)	◯ Take 1 tablet by mouth once daily	
◯ **XELJANZ®**	◯ 10mg tablets (quantity QS for length of starter dose therapy, in multiples of 60 tablets)	◯ **Starter Dose:** Take 10mg by mouth twice daily for _____ weeks	**No Refills**
	◯ 5mg tablets (30 day supply) ◯ 10mg tablets (30 day supply)	◯ **Maintenance Dose:** Take 1 tablet by mouth two times a day	
◯ **XELJANZ® XR**	◯ 22mg tablets (quantity QS for length of starter dose therapy, in multiples of 30 tablets)	◯ **Starter Dose:** Take 22mg by mouth once daily for _____ weeks	**No Refills**
	◯ 11mg tablets (30 day supply) ◯ 22mg tablets (30 day supply)	◯ **Maintenance Dose:** Take 1 tablet by mouth once daily	
◯ **XIFAXAN®**	◯ 200mg tablet ◯ 550mg tablet	◯ Take 1 tablet by mouth 2 times a day for _____ days ◯ Take 1 tablet by mouth 3 times a day for _____ days	
◯ **ZEPOSIA®**	◯ Starter Pack (7 day supply) ◯ Starter Kit (37 day supply)	◯ Take 0.23mg by mouth daily on days 1-4, then 0.46mg daily on days 5-7, then 0.92mg daily thereafter	
	◯ 0.92mg capsules (30 day supply)	◯ **Maintenance Dose:** Take 1 capsule by mouth daily	
◯ **ZYMFENTRA™** (infliximab-dyyb) ◯ PFS ◯ Pen	◯ 1 carton (2x120mg/ml)	**Maintenance Dose:** ◯ Inject 120mg SQ every 2 weeks, starting at week 10	

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

Substitution Permitted

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

MSP-Gastro-041624