meijer specialty pharmacy

P: 1-855-263-4537 • F: 734-391-2365
www.meijerspecialtypharmacy.com

○ New/Changed Dose

General Therapy

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
Office Contact:	Practice Name / Collaborating MD:					
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: / /			

Medical History

Has patient been treated previously for this condition? ○ Y ○ N	Medication(s):
Is patient currently on therapy? ○ Y ○ N	Medication(s):

Will patient stop taking the above medication(s) before starting the new medication(s)? ○ Y ○ N **If Yes, how long should patient wait before starting the new medication?**

Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

Primary Diagnosis: (ICD-10/Diagnosis Code & Description)

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
○				
○				
○				
○				
○				
○				
○				
○				
○				

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.