

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:	HIPPA 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: / /				
Dermatology • 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:					
Gastroenterology • 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)			
Rheumatology • 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							
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			
BENLYSTA®	Number of 120mg/5ml vials: _____	Starter Dose: Infuse _____mg IV over 1 hour at weeks 0, 2, and 4		No Refills			
	Number of 400mg/20ml vials: _____	Maintenance Dose: Infuse _____mg IV over 1 hour once every 4 weeks					
ENTYVIO®	Starter Dose: 2 vials	Starter Dose: Infuse 300mg IV over 30 minutes at weeks 0 and 2		No Refills			
	Maintenance Dose: Number of 300mg vials: _____	Maintenance Dose: Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6					
ORENCIA®	Number of 250mg vials: _____	Starter Dose: Infuse _____mg IV in 100ml NS over 30 minutes at weeks 0 and 2		No Refills			
		Maintenance Dose: Infuse _____mg IV in 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter					
REMICADE®	Number of 100mg vials: _____	Starter Dose: Infuse _____mg IV over 2 hours at weeks 0, 2 and 6		No Refills			
		Maintenance Dose: Infuse _____mg IV over 2 hours once every _____ weeks					
RITUXAN®	Number of 100mg/10ml vials: _____	Starter Dose: Infuse 1000mg IV over 4-6 hours on day 1 and day 15		No Refills			
	Number of 500mg/50ml vials: _____	Maintenance Dose: Infuse 1000mg IV over 4-6 hours every _____ weeks					
SIMPONI ARIA®	Number of 50mg/4ml vials: _____	Starter Dose: Infuse _____mg IV over 30 minutes at weeks 0 and 4		No Refills			
		Maintenance Dose: Infuse _____mg IV over 30 minutes once every 8 weeks					
SKYRIZI®	1 Vial (600mg/10ml)	Starter Dose: Infuse 600mg IV over at least 1 hour at week 0, week 4 and week 8. Begin SQ maintenance regimen at week 12		2 Refills			
STELARA®	Number of 45mg/0.5ml vials: _____	Starter Dose: Begin the SQ maintenance regimen 8 weeks after the initial IV dose Weight > 85kg: Infuse 520mg IV over 1 hour Weight 56kg - 85kg: Infuse 390mg IV over 1 hour Weight ≤ 55kg: Infuse 260mg IV over 1 hour		No Refills			
	Number of 130mg/26ml vials: _____						

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.