meijer specialty pharmacy

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

○ New/Changed Dose

IV - Dermatology, Gastroenterology, Rheumatology (A-O)

Benlysta®, Cosentyx®, Entyvio®, Omvoh™, Orencia®

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: / /			

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: _____ ○ Number of 400mg/20ml vials: _____	○ **Starter Dose:** Infuse _____mg IV over 1 hour at weeks 0, 2, and 4	**No Refills**
		○ **Maintenance Dose:** Infuse _____mg IV over 1 hour once every 4 weeks	
○ **COSENTYX®**	○ Number of 125mg/5ml vials: _____	**Starter Dose:** ○ Infuse _____mg at week 0 ○ No starter dose	**No Refills**
	○ Number of 125mg/5ml vials: _____	○ **Maintenance Dose:** Infuse _____mg 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	
○ **OMVOH™**	○ Number of 300mg/15ml vials: _____	○ **Starter Dose:** Infuse 300mg at weeks 0, 4 and 8. Begin SQ maintenance dosing at week 12.	**No Refills**
○ **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	

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.