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○ New/Changed Dose

IV - Dermatology, Gastroenterology, Rheumatology (R-Z)

Remicade®, Rituxan®, Simponi Aria®, Skyrizi®
Stelara®, Tyenne®

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)	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) ○ 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 of 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
○ **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: _____ ○ Number of 500mg/50ml vials: _____	○ **Starter Dose:** Infuse 1000mg IV over 4-6 hours on day 1 and day 15	**No Refills**
		○ **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: _____ ○ Number of 130mg/26ml 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**
○ **TYENNE®** (tocilizumab-aazg)	○ Number of 80mg/4ml vials: _____ ○ Number of 200mg/10ml vials: _____ ○ Number of 400mg/20ml vials: _____	○ Infuse _____ mg IV over 60 minutes every 4 weeks ○ Infuse _____ mg IV over 60 minutes every 2 weeks	

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-IV-042424