meijer specialty pharmacy

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Rheumatology (A-E)

Actemra®, Benlysta®, Cimzia®, Cosentyx®, Enbrel®

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:	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: / /			

Clinical Information • 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 Juvenille 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:	Reason for Discontinuation of Therapy:	Approx. Start Date: / /
		Approx. End Date: / /

Comorbidities:	Concomitant Medications:	Allergies: ◯ NKDA ◯ Other:

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **ACTEMRA®** ◯ PFS ◯ ACTPen®	◯ 2 cartons (2x162mg/0.9ml) ◯ 4 cartons (4x162mg/0.9ml)	◯ Inject 162 mg SQ every other week (<100kg) ◯ Inject 162 mg SQ every week (>100kg)	
◯ **BENLYSTA®** ◯ PFS ◯ Pen	◯ 1 carton (4x200mg/ml autoinjector) ◯ 1 carton (4x200mg/ml PFS)	◯ **Maintenance Dose:** Administer 200mg SQ once every week	
◯ **CIMZIA®** ◯ PFS ◯ Vial	◯ **PFS Only:** Starter Kit (6x200mg/ml)	◯ **Starter Dose:** Inject 400 mg SQ at weeks 0, 2, and 4	**No Refills**
	◯ 1 carton (6x200 mg/ml)	◯ **Maintenance Dose:** Inject 400 mg SQ every 4 weeks ◯ **Maintenance Dose:** Inject 200 mg SQ every 2 weeks	
◯ **COSENTYX®** **Pediatrics (age 2 & older)*	◯ 4 cartons (4x75mg/0.5ml) PFS ◯ 4 cartons (4x150mg/ml) PFS ◯ 4 cartons (4x150mg/ml) PEN	**Starter Dose:** ◯ **Weight 15-49kg:** Inject 75mg SQ at weeks 0, 1, 2 and 3. ◯ **Weight ≥ 50kg:** Inject 150mg SQ at weeks 0, 1, 2 and 3.	**No Refills**
	◯ 1 carton (1x75mg/0.5ml) PFS ◯ 1 carton (1x150mg/ml) PFS ◯ 1 carton (1x150mg/ml) PEN	**Maintenance Dose:** ◯ **Weight 15-49kg:** Inject 75mg SQ every 4 weeks beginning on Day 29. ◯ **Weight ≥ 50kg:** Inject 150mg SQ every 4 weeks beginning on Day 29.	
◯ **COSENTYX®** **Adults* ◯ PFS ◯ Sensoready® Pen	◯ 4 cartons (8x150mg/ml) ◯ 4 cartons (4x150mg/ml)	◯ **Starter Dose:** Inject 300 mg SQ at weeks 0, 1, 2, 3 ◯ **Starter Dose:** Inject 150 mg SQ at weeks 0, 1, 2, 3	**No Refills**
	◯ 1 carton (2x150mg/ml) ◯ 1 carton (1x150mg/ml)	◯ **Maintenance Dose:** Inject 300 mg SQ every 4 weeks beginning on Day 29 ◯ **Maintenance Dose:** Inject 150 mg SQ every 4 weeks beginning on Day 29	
◯ **ENBREL®** ◯ Mini™ ◯ PFS ◯ SureClick® ◯ Vial	◯ 1 carton (4 x 50mg/ml) ◯ Other:	◯ Inject 50 mg SQ every week ◯ Other Regimen:	

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.