meijer specialty pharmacy

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Rheumatology (H-0)

Humira®, Ilaris®, Kevzara®, Olumiant®, Orencia®, Otezla®, Otrexup™,

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
◯ **HUMIRA®** ◯ **PFS** ◯ **Pen**	**Citrate Free** ◯ 1 carton (2x40mg/0.4ml) ◯ 2 cartons (4x40mg/0.4ml) ◯ 1 carton (2x80mg/0.8ml) PEN ONLY	◯ Inject 40mg SQ every other week ◯ Inject 40mg SQ every week* ◯ Inject 80mg SQ every other week* **For patients with moderate-to-severe disease not taking concomitant MTX*	
◯ **HUMIRA®** ***Pediatrics**	◯ 1 carton (2x10mg/0.1mL PFS) ◯ 1 carton (2x20mg/0.2mL PFS) ◯ 1 carton (40mg/0.4mL PFS) ◯ 1 carton (40mg/0.4mL PEN)	◯ **Weight 10-14kg:** Inject 10mg SQ every other week ◯ **Weight 15-29kg:** Inject 20mg SQ every other week ◯ **Weight ≥30kg:** Inject 40mg SQ every other week	
◯ **HUMIRA®** ***Uveitis**	◯ **Pens Only:** Citrate Free Starter Kit (1x80mg/0.8ml, 2x40mg/0.4ml)	◯ Inject 80mg SQ on Day 1, then 40mg on day 8, then 40mg every 2 weeks	**No Refills**
	◯ Citrate Free 1 carton (2x40mg/0.4ml)	◯ Inject 40mg SQ every 14 days	
◯ **ILARIS®**	◯ 150mg/ml vial (28 day supply)	◯ Inject _____ mg SQ every 4 weeks ◯ **Other:**	
◯ **KEVZARA®** ◯ **PFS** ◯ **Pen**	◯ 1 carton (2x200mg/1.14ml) ◯ 1 carton (2x150mg/1.14ml)	◯ Inject 200mg SQ every 2 weeks ◯ Inject 150mg SQ every 2 weeks	
◯ **OLUMIANT®**	◯ 2mg tablet (30 day supply)	◯ Take 1 tablet by mouth once daily	
◯ **ORENCIA®** ◯ **Clickject®** ◯ **PFS**	◯ 1 carton (4x125mg/ml)	◯ **Maintenance Dose:** Inject 125 mg SQ once every week	
◯ **OTEZLA®**	◯ **Starter Pack:** 10/20/30mg tablets (55 tabs for 28 days)	◯ **Starter Dose:** Take as directed per package instructions	**No Refills**
	◯ 30 mg tablet (60 tablets)	◯ **Maintenance Dose:** Take 1 tablet (30mg) by mouth twice daily	
◯ **OTREXUP™**	◯ 1 carton (4x10mg/0.4ml) ◯ 1 carton (4x20mg/0.4ml) ◯ 1 carton (4x12.5mg/0.4ml) ◯ 1 carton (4x22.5mg/0.4ml) ◯ 1 carton (4x15mg/0.4ml) ◯ 1 carton (4x25mg/0.4ml) ◯ 1 carton (4x17.5mg/0.4ml)	◯ Inject _____mg SQ every week	

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.