


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: / /		

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 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:		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® *Adults	PFS Pen	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
HUMIRA® *Pediatrics age 2+	PFS Pen	1 carton (2x10mg/0.1ml) – PFS ONLY 1 carton (2x20mg/0.2ml) – PFS ONLY 1 carton (2x40mg/0.4ml)	Weight 10kg (22lbs) to < 15kg (33lbs): Inject 10mg SQ every other week Weight 15kg (33lbs) to < 30kg (66lbs): Inject 20mg SQ every other week Weight ≥ 30kg (66lbs): Inject 40mg SQ every other week
		 To prescribe a biosimilar, please use the Humira & Biosimilars Referral Form. Scan QR Code or click this link to view Referral Form.	
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® *Adults	Clickject® PFS	1 carton (4x125mg/ml)	Maintenance Dose: Inject 125 mg SQ once every week
ORENCIA® *Pediatrics		1 carton (4x125mg/ml) Clickject® Pen 1 carton (4x125mg/ml) PFS 1 carton (4x87.5mg/0.7ml) 1 carton (4x50mg/0.4ml)	Weight 10-24kg: Inject 50mg SQ once every week Weight 25-49kg: Inject 87.5mg SQ once every week Weight 50kg+: Inject 125mg SQ once every week
OTEZLA®	Starter Pack: 10/20/30mg tablets (55 tabs for 28 days)		Starter Dose: Take as directed per package instructions
	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
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Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.