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○ **New/Changed Dose**

Humira & Biosimilars

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	Dose/Strength	Sig	Quantity	Refills
○				
○				
○				
○				
○				
○				

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

Scan QR Code or click here to view the Humira & Biosimilars Prescribing Guide.

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