

**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 <b>If Yes, list allergies:</b>							

**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**

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	<b>If Yes, is patent currently treated? Y N</b>
Prior Treatment? Y N (Provide Information Below)	BSA Affected (%):	Affected Areas: Palms Soles Head Neck Genitalia Other:				
Prior Therapy:		Reason for Discontinuation of Therapy:			Approx. Start Date: / /	Approx. End Date: / /
Comorbidities:		Concomitant Medications:				

**Prescription Information**

Medication	Quantity/Dose	Sig	Refills
<b>TALTZ®</b> (Plaque Psoriasis) Autoinjector PFS	3x80mg/ml	<b>Starter Dose:</b> Inject 160mg SQ on Day 0 and 80mg SQ at week 2	<b>No Refills</b>
	2x80mg/ml	<b>Titration Dose:</b> Inject 80mg SQ at weeks 4, 6, 8, 10	<b>1 Refill</b>
	1x80mg/ml	<b>Maintenance Dose:</b> Inject 80mg SQ every 4 weeks starting at week 12	
<b>TALTZ®</b> (Pediatric Plaque Psoriasis) PFS	2x80mg/ml 1x80mg/ml	<b>Starter Dose:</b> Patients >50kg: Inject 160mg at week 0. Begin maintenance dosing at week 4 Patients 25-50kg: Inject 80mg at week 0. Begin maintenance dosing at week 4. Patients <25kg: Inject 40mg at week 0. Begin maintenance dosing at week 4.	
	1x80mg/ml	<b>Maintenance Dose:</b> Patients >50kg: Inject 80mg every 4 weeks Patients 25-50kg: Inject 40mg every 4 weeks Patients <25kg: Inject 20mg every 4 weeks.	
<b>TALTZ®</b> (Psoriatic Arthritis) Autoinjector PFS	2x80mg/ml	<b>Starter Dose:</b> Inject 160mg SQ on Day 0	<b>No Refills</b>
	1x80mg/ml	<b>Maintenance Dose:</b> Inject 80mg SQ every 4 weeks starting at week 4	
<b>TREMFYA®</b> PFS OnePress	2 cartons (2x100mg/mL)	<b>Starter Dose:</b> Inject 100 mg SQ at weeks 0 and 4	<b>No Refills</b>
	1 carton (1x100mg/mL)	<b>Maintenance Dose:</b> Inject 100 mg SQ every 8 weeks	
<b>XOLAIR®</b> PFS Vial Pen Sterile water for injection (to be used with Xolair vials) Number of vials: _____ Refills: _____	Number of 75mg/0.5ml pens/syringes: _____ Number of 150mg/ml pens/syringes: _____ Number of 300mg/2ml pens/syringes: _____ Number of 150mg vials: _____	Inject 150mg SQ every 4 weeks Inject 300mg SQ every 4 weeks	

**Injection Training**

Patient received injection training	Prescriber's office to provide injection training	Meijer to coordinate injection training
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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.