


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					
ICD-10/Diagnosis Code:	<b>Crohn's Disease:</b>	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)
<b>Ulcerative Colitis:</b>	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)	
Prior Therapy:		Reason for Discontinuation of Therapy:			Approx. Start Date: / /
					Approx. End Date: / /

Prescription Information			
Medication	Quantity/Dose	Sig	Refills
<b>CIMZIA®</b> PFS Vials	Prefilled Syringe Starter Kit (6x200mg/ml) 1 carton (2x200mg/ml)	<b>Starter Dose:</b> Inject 400mg SQ at weeks 0, 2, and 4 <b>Maintenance Dose:</b> Inject 400mg SQ every 4 weeks <b>Maintenance Dose:</b> Inject 200mg SQ every 2 weeks	
<b>DUPIXENT®</b> Pen PFS	2 cartons (4x300mg/2ml)	Inject 300mg SQ once weekly	
<b>HUMIRA®</b>	 <p>To prescribe Humira, please use the Humira &amp; Biosimilars Referral form. Scan QR Code or <a href="#">click this link</a> to view Referral Form.</p>		
<b>OMVOH™</b>	1 carton (2x100mg/ml PEN)	Inject 200mg (two syringes) SQ every 4 weeks, starting at week 12	
<b>RINVOQ®</b>	45mg tablets (28 day supply)	<b>CD Starter Dose:</b> Take 1 tablet by mouth daily for 12 weeks	<b>2</b>
	15mg tablets (30 day supply) 30mg tablets (30 day supply)	<b>UC Starter Dose:</b> Take 1 tablet by mouth daily for 8 weeks <b>Maintenance Dose:</b> Take 1 tablet by mouth daily	<b>1</b>

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.