

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:		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: / /		
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	Quantity/Dose	Sig				Refills
BENLYSTA®	Number of 120mg/5ml vials: _____	Starter Dose: Infuse ___mg IV over 1 hour at weeks 0, 2, and 4				No Refills
	Number of 400mg/20ml vials: _____	Maintenance Dose: Infuse ___mg IV over 1 hour once every 4 weeks				
ENTYVIO®	Starter Dose: 2 vials	Starter Dose: Infuse 300mg IV over 30 minutes at weeks 0 and 2				No Refills
	Maintenance Dose: Number of 300mg vials: _____	Maintenance Dose: Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6				
ORENCIA®	Number of 250mg vials: _____	Starter Dose: Infuse ___mg IV in 100ml NS over 30 minutes at weeks 0 and 2				No Refills
		Maintenance Dose: Infuse ___mg IV in 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter				
REMICADE®	Number of 100mg vials: _____	Starter Dose: Infuse ___mg IV over 2 hours at weeks 0, 2 and 6				No Refills
		Maintenance Dose: Infuse ___mg IV over 2 hours once every ___ weeks				
RITUXAN®	Number of 100mg/10ml vials: _____ Number of 500mg/50ml vials: _____	Starter Dose: Infuse 1000mg IV over 4-6 hours on day 1 and day 15				No Refills
		Maintenance Dose: Infuse 1000mg IV over 4-6 hours every ___ weeks				
SIMPONI ARIA®	Number of 50mg/4ml vials: _____	Starter Dose: Infuse ___mg IV over 30 minutes at weeks 0 and 4				No Refills
		Maintenance Dose: Infuse ___mg IV over 30 minutes once every 8 weeks				
SKYRIZI®	1 Vial (600mg/10ml)	Starter Dose: Infuse 600mg IV over at least 1 hour at week 0, week 4 and week 8. Begin SQ maintenance regimen at week 12				2 Refills
STELARA®	Number of 45mg/0.5ml vials: _____ Number of 130mg/26ml vials: _____	Starter Dose: Begin the SQ maintenance regimen 8 weeks after the initial IV dose				No Refills
		Weight > 85kg: Infuse 520mg IV over 1 hour Weight 56kg - 85kg: Infuse 390mg IV over 1 hour Weight ≤ 55kg: Infuse 260mg IV over 1 hour				

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.