

New/Changed Dose

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	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						
COSENTYX®	Number of 125mg/5ml vials: _____			Starter Dose: Infuse _____mg at week 0 No starter dose				No Refills		
	Number of 125mg/5ml vials: _____			Maintenance Dose: Infuse _____mg 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						
OMVOH™	Number of 300mg/15ml vials: _____			Starter Dose: Infuse 300mg at weeks 0, 4 and 8. Begin SQ maintenance dosing at week 12.				No Refills		
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						

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.