

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
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: / /				
Clinical Information • 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:				Reason for Discontinuation of Therapy:				Approx. Start Date: / /	
								Approx. End Date: / /	
Comorbidities:			Concomitant Medications:			Allergies: NKDA Other:			
Prescription Information									
Medication	Quantity/Dose				Sig			Refills	
RASUVO® Auto-Injector	4x7.5mg/0.15ml 4x10mg/0.20ml 4x12.5mg/0.25ml 4x15mg/0.30ml 4x17.5mg/0.35ml		4x20mg/0.4ml 4x22.5mg/0.45ml 4x25mg/0.50ml 4x30mg/0.60ml		Inject ____ mg SQ every week				
RINVOQ™	15mg tablet (30 day supply)				Take 1 tablet by mouth once daily				
SIMPONI® SmartJect® PFS	1 carton (1x50mg/0.5ml)				Inject 50 mg SQ once every month				
SKYRIZI™ PFS Pen	1 carton (150mg/ml)				Starter Dose: Inject 150mg SQ at weeks 0 and 4			1 Refill	
	1 carton (150mg/ml)				Maintenance Dose: Inject 150mg SQ every 12 weeks				
STELARA® *Adults Patient eligible for self-injection? Y N	1 carton (1x45mg/0.5ml) 1 carton (1x90mg/ml)				Starter Dose: Inject 45 mg SQ on day 1 (<100kg) Starter Dose: Inject 90 mg SQ on day 1 (>100kg)			No Refills	
					Maintenance Dose: Inject 45 mg SQ on day 29 and every 12 weeks thereafter (<100kg) Maintenance Dose: Inject 90 mg SQ on day 29 and every 12 weeks thereafter (>100kg)				
STELARA® *Pediatrics	1 carton (1x45mg/0.5mL) PFS 1 carton (1x90mg/mL) PFS 1 vial (45mg/0.5mL)				Starter Dose: Patients <60kg: Inject 0.75mg/kg SQ on day 1 Patients 60kg-100kg: Inject 45mg SQ on day 1 Patients >100kg: Inject 90mg SQ on day 1			No Refills	
	1 carton (1x45mg/0.5mL) PFS 1 carton (1x90mg/mL) PFS 1 vial (45mg/0.5mL)				Maintenance Dose: Patients <60kg: Inject 0.75mg/kg SQ once every 12 weeks, starting on day 29 Patients 60kg-100kg: Inject 45mg SQ once every 12 weeks, starting on day 29 Patients >100kg: Inject 90mg SQ once every 12 weeks, starting on day 29				
TALTZ® Auto-Injector PFS	2x80mg/ml				Starter Dose: Inject 160mg SQ at week 0			No Refills	
	1 carton (1x80mg/ml) 3 cartons (3x80mg/ml)				Maintenance Dose: Inject 80mg SQ every 4 weeks				
TREMFYA® PFS OnePress	2 cartons (2x100mg/ml)				Starter Dose: Inject 100 mg SQ at weeks 0 and 4			No Refills	
	1 carton (1x100mg/ml)				Maintenance Dose: Inject 100 mg SQ every 8 weeks				
XELJANZ® *Pediatrics (age 2 & up)	5mg tablets (60 tablets) 1mg/ml oral solution (quantity QS for 30 day supply in multiples of 240ml)				Weight 10-19kg: Take 3.2mg (3.2ml oral solution) by mouth two times daily Weight 20-39kg: Take 4mg (4ml oral solution) by mouth two times daily Weight ≥ 40kg: Take 5mg by mouth two times daily				
XELJANZ®	5 mg tablets (60 tablets)				Take 1 tablet (5 mg) by mouth twice a day				
XELJANZ® XR	11 mg tablets (30 tablets)				Take 1 tablet (11mg) by mouth every day				
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.