meijer specialty pharmacy

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Rheumatology (R-Z)

Rasuvo®, Rinvoq®, Simponi®, Stelara®, Taltz®, Tremfya®, Xeljanz®, Xeljanz® XR

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: / /			

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 Juvenille 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®** ◯ PFS 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)	
◯ **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

Substitution Permitted

Dispense as Written
If brand is required, please write "DAW" in the box to the right.