meijer specialty pharmacy

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◯ **New/Changed Dose**

Dermatology (A-C)

Adbry™, Bimzelx®, Cibinqo™, Cimzia®, Cosentyx®

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:	◯ Alopecia areata (L63)	◯ 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.____)	◯ Other:
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:		
Prior Therapy:	Reason for Discontinuation of Therapy:	Approx. Start Date: / /		
		Approx. End Date: / /		
Comorbidities:	Concomitant Medications:			

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **ADBRY™**	◯ 1 carton (4x150mg/mL)	**Starter Dose:** ◯ Inject 600mg (four 150mg injections) SQ at week 0. Begin maintenance dosing at week 2.	**No Refills**
	◯ 1 carton (2x150mg/mL) ◯ 1 carton (4x150mg/mL)	**Maintenance Dose:** ◯ Inject 300mg (two 150mg injections) SQ every other week ◯ Inject 300mg (two 150mg injections) SQ every 4 weeks	
◯ **BIMZELX®** ◯ PFS ◯ Pen	◯ 1 carton (2x160mg/mL)	◯ **Starter Dose:** Inject 320mg (two 160mg injections) SQ at weeks 0, 4, 8, 12 and 16	**4**
	◯ 1 carton (2x160mg/mL)	**Maintenance Dose:** ◯ Inject 320mg (two 160mg injections) SQ every 8 weeks ◯ Inject 320mg (two 160mg injections) SQ every 4 weeks	
◯ **CIBINQO™**	◯ 50mg tablet (30 day supply) ◯ 100mg tablet (30 day supply) ◯ 200mg tablet (30 day supply)	◯ Take 1 tablet by mouth daily	
◯ **CIMZIA®** ◯ PFS ◯ Vials	◯ 1 starter kit (6x200mg/ml)	◯ **Starter Dose:** Inject 400mg SQ at weeks 0, 2 and 4	**No Refills**
	◯ 1 carton (2x200mg/mL) ◯ 2 cartons (4x200mg/mL)	**Maintenance Dose:** ◯ Inject 400mg SQ every 4 weeks ◯ Inject 200mg SQ every 2 weeks ◯ Inject 400mg SQ every other week **(plaque psoriasis only)** ◯ Inject 200mg SQ every other week	
COSENTYX® **Pediatrics (age 6 & older)*	◯ 4 cartons (4x75mg/0.5ml) PFS ◯ 4 cartons (4x150mg/ml) PFS ◯ 4 cartons (4x150mg/ml) PEN	**Starter Dose:** ◯ **Weight < 50kg:** Inject 75mg SQ at weeks 0, 1, 2, and 3 ◯ **Weight ≥ 50kg:** Inject 150mg SQ at weeks 0, 1, 2, and 3	**No Refills**
	◯ 1 carton (1x75mg/0.5ml) PFS ◯ 1 carton (1x150mg/ml) PFS ◯ 1 carton (1x150mg/ml) PEN	**Maintenance Dose:** ◯ **Weight < 50kg:** Inject 75mg SQ every 4 weeks beginning on Day 29 ◯ **Weight ≥ 50kg:** Inject 150mg SQ every 4 weeks beginning on Day 29	
◯ **COSENTYX®** **Adults* ◯ PFS ◯ Sensoready® Pen/Unoready® Pen	◯ 4 cartons (4x300mg/2mL) ◯ 4 cartons (8x150mg/mL) ◯ 4 cartons (4x150mg/mL)	**Starter Dose:** ◯ Inject 300 mg SQ at weeks 0, 1, 2, and 3 ◯ Inject 150 mg SQ at weeks 0, 1, 2, and 3	**No Refills**
	◯ 1 carton (1x300mg/2mL) ◯ 1 carton (2x150mg/mL) ◯ 1 carton (1x150mg/mL)	**Maintenance Dose:** ◯ Inject 300 mg SQ every 4 weeks beginning on Day 29 ◯ Inject 300 mg SQ every 2 weeks beginning on Day 29 ◯ Inject 150 mg SQ every 4 weeks beginning on Day 29	

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.