Meijer specialty pharmacy

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www.meijerspecialtypharmacy.com

New/Changed Dose

Gastroenterology (A-N)

Cimzia®, Dupixent®, Humira®

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

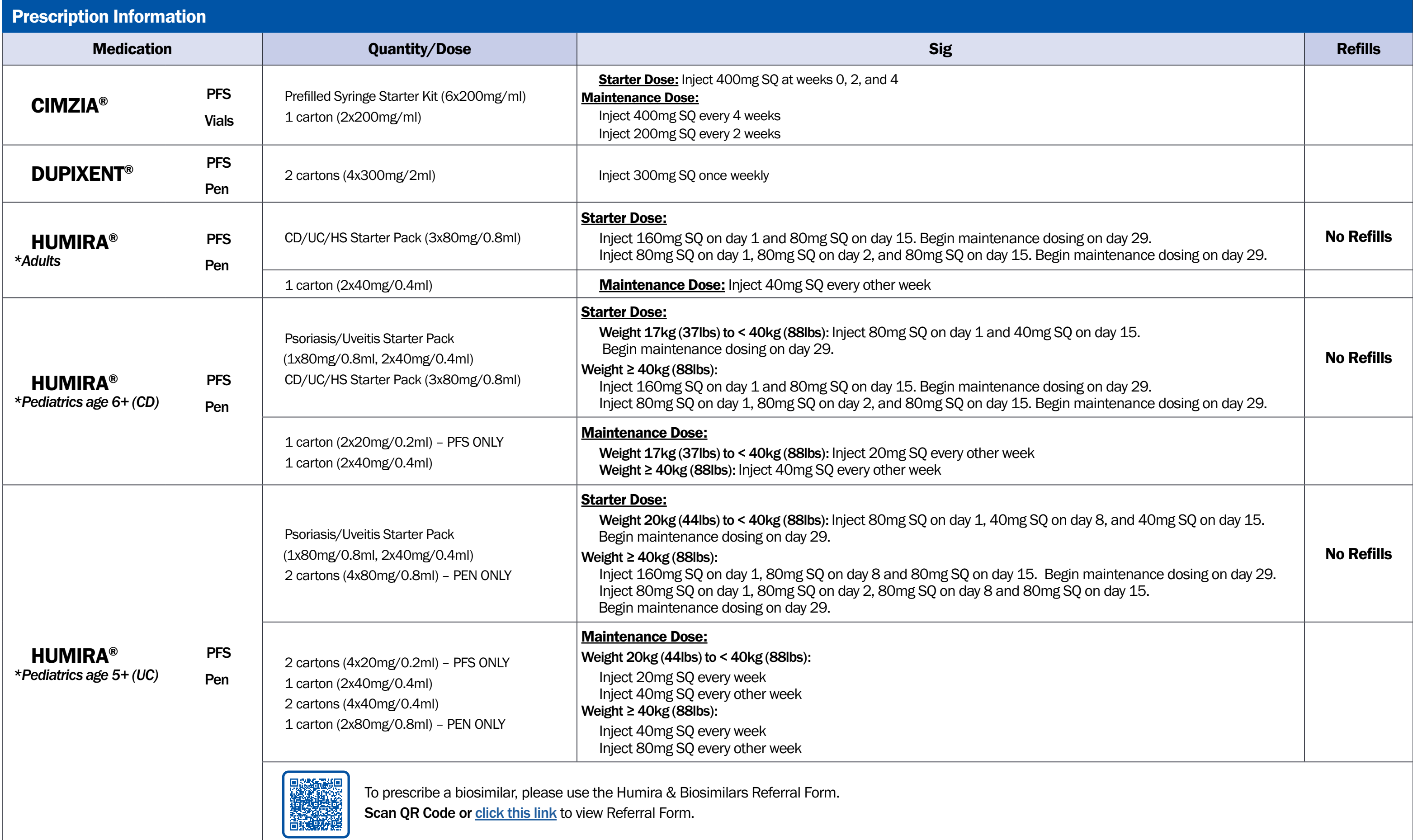
ICD-10/Diagnosis Code: **Crohn's Disease:** K50.0___(Crohn's of the **Small** Intestine) K50.1___(Crohn's of the Large Intestine) K50.8___(Crohn's of Both Intestines) K50.9___(Crohn's, Unspecified)

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)**
Prior Therapy:	Reason for Discontinuation of Therapy:	Approx. Start Date: / / Approx. End Date: / /

Prescription Information



Medication		Quantity/Dose	Sig	Refills
CIMZIA®	PFS Vials	Prefilled Syringe Starter Kit (6x200mg/ml) 1 carton (2x200mg/ml)	**Starter Dose:** Inject 400mg SQ at weeks 0, 2, and 4 **Maintenance Dose:** Inject 400mg SQ every 4 weeks Inject 200mg SQ every 2 weeks	
DUPIXENT®	PFS Pen	2 cartons (4x300mg/2ml)	Inject 300mg SQ once weekly	
HUMIRA® *Adults*	PFS Pen	CD/UC/HS Starter Pack (3x80mg/0.8ml)	**Starter Dose:** Inject 160mg SQ on day 1 and 80mg SQ on day 15. Begin maintenance dosing on day 29. Inject 80mg SQ on day 1, 80mg SQ on day 2, and 80mg SQ on day 15. Begin maintenance dosing on day 29.	**No Refills**
		1 carton (2x40mg/0.4ml)	**Maintenance Dose:** Inject 40mg SQ every other week	
HUMIRA® *Pediatrics age 6+ (CD)*	PFS Pen	Psoriasis/Uveitis Starter Pack (1x80mg/0.8ml, 2x40mg/0.4ml) CD/UC/HS Starter Pack (3x80mg/0.8ml)	**Starter Dose:** **Weight 17kg (37lbs) to < 40kg (88lbs):** Inject 80mg SQ on day 1 and 40mg SQ on day 15. Begin maintenance dosing on day 29. **Weight ≥ 40kg (88lbs):** Inject 160mg SQ on day 1 and 80mg SQ on day 15. Begin maintenance dosing on day 29. Inject 80mg SQ on day 1, 80mg SQ on day 2, and 80mg SQ on day 15. Begin maintenance dosing on day 29.	**No Refills**
		1 carton (2x20mg/0.2ml) – PFS ONLY 1 carton (2x40mg/0.4ml)	**Maintenance Dose:** **Weight 17kg (37lbs) to < 40kg (88lbs):** Inject 20mg SQ every other week **Weight ≥ 40kg (88lbs):** Inject 40mg SQ every other week	
HUMIRA® *Pediatrics age 5+ (UC)*	PFS Pen	Psoriasis/Uveitis Starter Pack (1x80mg/0.8ml, 2x40mg/0.4ml) 2 cartons (4x80mg/0.8ml) – PEN ONLY	**Starter Dose:** **Weight 20kg (44lbs) to < 40kg (88lbs):** Inject 80mg SQ on day 1, 40mg SQ on day 8, and 40mg SQ on day 15. Begin maintenance dosing on day 29. **Weight ≥ 40kg (88lbs):** Inject 160mg SQ on day 1, 80mg SQ on day 8 and 80mg SQ on day 15. Begin maintenance dosing on day 29. Inject 80mg SQ on day 1, 80mg SQ on day 2, 80mg SQ on day 8 and 80mg SQ on day 15. Begin maintenance dosing on day 29.	**No Refills**
		2 cartons (4x20mg/0.2ml) – PFS ONLY 1 carton (2x40mg/0.4ml) 2 cartons (4x40mg/0.4ml) 1 carton (2x80mg/0.8ml) – PEN ONLY	**Maintenance Dose:** **Weight 20kg (44lbs) to < 40kg (88lbs):** Inject 20mg SQ every week Inject 40mg SQ every other week **Weight ≥ 40kg (88lbs):** Inject 40mg SQ every week Inject 80mg SQ every other week	

To prescribe a biosimilar, please use the Humira & Biosimilars Referral Form.
Scan QR Code or click this link to view Referral Form.

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.**	