meijer specialty pharmacy

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◯ New/Changed Dose

Gastroenterology (O-R)

Omvoh™, Rinvoq®

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
◯ **OMVOH™**	◯ 1 carton (2x100mg/ml PEN)	◯ Inject 200mg (two syringes) SQ every 4 weeks, starting at week 12	
◯ **RINVOQ®**	◯ 45mg tablets (28 day supply)	◯ **CD Starter Dose:** Take 1 tablet by mouth daily for 12 weeks	**2**
		◯ **UC Starter Dose:** Take 1 tablet by mouth daily for 8 weeks	**1**
	◯ 15mg tablets (30 day supply) ◯ 30mg tablets (30 day supply)	◯ **Maintenance Dose:** Take 1 tablet by mouth daily	

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.