meijer specialty pharmacy

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◯ New/Changed Dose

IV - Dermatology, Gastroenterology, Rheumatology (A-O)

Actemra®, Benlysta®, Cosentyx®, Entyvio®, Omvoh™, Orencia®

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: / /			

Dermatology • 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: ◯ 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)	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	BSA Affected (%):	Affected Areas: ◯ Palms ◯ Soles ◯ Head ◯ Neck ◯ Genitalia ◯ Other:		

Gastroenterology • 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: ◯ K50.__ (Crohn's Disease) ◯ K51.__ (Ulcerative Colitis) ◯ Other:		
Date of Diagnosis: / /	Date of Negative TB Test: / /	Prior Treatment? ◯ Y ◯ N

Rheumatology • 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: ◯ 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 of Diagnosis: / /	Date of Neg. TB Test: / /	Any prior treatment? ◯ Y ◯ N

Notes to Pharmacy

Prescription Information

	Quantity/Dose	Sig	Refills
◯ **ACTEMRA®** (tocilizumab)	◯ Number of 80mg/4ml vials: _____ ◯ Number of 200mg/10ml vials: _____ ◯ Number of 400mg/20ml vials: _____	◯ Infuse _____ mg IV over 60 minutes every 4 weeks ◯ Infuse _____ mg IV over 60 minutes every 2 weeks	
◯ **BENLYSTA®** (belimumab)	◯ Number of 120mg/5ml vials: _____ ◯ Number of 400mg/20ml vials: _____	◯ **Starter Dose:** Infuse _____mg IV over 1 hour at weeks 0, 2, and 4	**No Refills**
		◯ **Maintenance Dose:** Infuse _____mg IV over 1 hour once every 4 weeks	
◯ **COSENTYX®** (secukinumab)	◯ Number of 125mg/5ml vials: _____	**Starter Dose:** ◯ Infuse _____mg at week 0 ◯ No starter dose	**No Refills**
	◯ Number of 125mg/5ml vials: _____	◯ **Maintenance Dose:** Infuse _____mg every 4 weeks	
◯ **ENTYVIO®** (vedolizumab)	◯ 2 vials (300mg each)	◯ **Starter Dose:** Infuse 300mg IV over 30 minutes at weeks 0 and 2	**No Refills**
	◯ 1 vial (300mg)	◯ **Maintenance Dose:** Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6	
◯ **OMVOH™** (mirikizumab-mrkz)	◯ 1 vial (300mg/15ml) ◯ 3 vials (300mg/15ml)	◯ **UC Starter Dose:** Infuse 300mg IV at weeks 0, 4 and 8. Begin SQ maintenance dosing at week 12. ◯ **CD Starter Dose:** Infuse 900mg IV at weeks 0, 4 and 8. Begin SQ maintenance dosing at week 12.	**2 Refills**
◯ **ORENCIA®** (abatacept)	◯ Number of 250mg vials: _____	◯ **Starter Dose:** Infuse _____ mg IV at weeks 0 and 2	**No Refills**
		◯ **Maintenance Dose:** Infuse _____mg IV at week 4 and every 4 weeks thereafter	

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.