

New/Changed Dose

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

Medication	Quantity/Dose	Sig	Refills
REMICADE® (infliximab)	Number of 100mg vials: _____	Starter Dose: Infuse ____mg IV over 2 hours at weeks 0, 2 and 6 Maintenance Dose: Infuse ____mg IV over 2 hours once every ____ weeks	No Refills
RITUXAN® (rituximab)	Number of 100mg/10ml vials: _____ Number of 500mg/50ml vials: _____	Starter Dose: Infuse 1000mg IV over 4-6 hours on day 1 and day 15 Maintenance Dose: Infuse 1000mg IV over 4-6 hours every ____ weeks	No Refills
SIMPONI ARIA® (golimumab)	Number of 50mg/4ml vials: _____	Starter Dose: Infuse ____mg IV over 30 minutes at weeks 0 and 4 Maintenance Dose: Infuse ____mg IV over 30 minutes once every 8 weeks	No Refills
SKYRIZI® (risankizumab-rzaa)	1 Vial (600mg/10ml) 2 Vials (600mg/10ml)	CD Starter Dose: Infuse 600mg IV over at least 1 hour at week 0, week 4 and week 8. Begin SQ maintenance regimen at week 12 UC Starter Dose: Infuse 1,200mg IV over at least 2 hours at week 0, week 4 and week 8. Begin SQ maintenance regimen at week 12.	2 Refills
STELARA® (ustekinumab)	Number of 130mg/26ml vials: _____	Starter Dose: Begin the SQ maintenance regimen 8 weeks after the initial IV dose Weight > 85kg: Infuse 520mg IV over 1 hour Weight 56kg - 85kg: Infuse 390mg IV over 1 hour Weight ≤ 55kg: Infuse 260mg IV over 1 hour	No Refills
TREMFYA® (guselkumab)	1 vial (200mg/20ml)	Starter Dose: Infuse 200mg IV over 1 hour at weeks 0, 4 and 8	2 Refills

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
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Substitution Permitted

Dispense as Written

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

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