meijer specialty pharmacy

P: 1-855-263-4537 • F: 1-734-391-2365
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◯ **New/Changed Dose**

Rheumatology (R-S)

Rasuvo®, Rinvoq™, Simponi®, Skyrizi™, Stelara®

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

Patient 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

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

Notes to Pharmacy

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **RASUVO®** ◯ Auto-Injector	◯ 4x7.5mg/0.15ml ◯ 4x10mg/0.20ml ◯ 4x12.5mg/0.25ml ◯ 4x15mg/0.30ml ◯ 4x17.5mg/0.35ml ◯ 4x20mg/0.4ml ◯ 4x22.5mg/0.45ml ◯ 4x25mg/0.50ml ◯ 4x30mg/0.60ml	◯ Inject _____ mg SQ every week	
◯ **RINVOQ™** *Adults	◯ 15mg tablet (30 day supply)	◯ Take 1 tablet by mouth once daily	
◯ **RINVOQ™** *Pediatrics	◯ 1mg/ml oral solution (quantity QS for 30 day supply in multiples of 180ml) ◯ 15mg tablet (30 day supply)	◯ **Weight 10-19kg:** Take 3mg (3ml oral solution) by mouth two times daily ◯ **Weight 20-29kg:** Take 4mg (4ml oral solution) by mouth two times daily **Weight ≥ 30kg:** ◯ Take 6mg (6ml oral solution) by mouth twice daily ◯ Take 15mg (one 15mg tablet) by mouth once daily	
◯ **SIMPONI®** ◯ SmartJect® ◯ PFS	◯ 1 carton (1x50mg/0.5ml)	◯ Inject 50 mg SQ once every month	
◯ **SKYRIZI™** *Adults ◯ PFS ◯ Pen	◯ 1 carton (150mg/ml)	◯ **Starter Dose:** Inject 150mg SQ at weeks 0 and 4	**1 Refill**
	◯ 1 carton (150mg/ml)	◯ **Maintenance Dose:** Inject 150mg SQ every 12 weeks	
◯ **SKYRIZI™** *Pediatrics	◯ 1 carton (55mg/0.37mL) PFS ◯ 1 carton (150mg/mL) PFS ◯ 1 carton (150mg/mL) PEN	**Starter Dose:** ◯ **Weight <40kg:** Inject 55mg SQ at weeks 0 and 4 ◯ **Weight ≥ 40kg:** Inject 150mg SQ at weeks 0 and 4	**1 Refill**
	◯ 1 carton (55mg/0.37ml) PFS ◯ 1 carton (150mg/mL) PFS ◯ 1 carton (150mg/mL) PEN	**Maintenance Dose:** ◯ **Weight <40kg:** Inject 55mg SQ every 12 weeks ◯ **Weight ≥ 40kg:** Inject 150mg SQ every 12 weeks	
◯ **STELARA®** *Adults	◯ 1 carton (1x45mg/0.5ml) ◯ 1 carton (1x90mg/ml)	**Starter Dose:** ◯ **Weight < 100kg:** Inject 45mg SQ at weeks 0 and 4 ◯ **Weight > 100kg:** Inject 90mg SQ at weeks 0 and 4	**1 Refill**
		Maintenance Dose: ◯ **Weight < 100kg:** Inject 45mg SQ every 12 weeks ◯ **Weight > 100kg:** Inject 90mg SQ every 12 weeks	
◯ **STELARA®** *Pediatrics	◯ 1 carton (1x45mg/0.5mL) PFS ◯ 1 carton (1x90mg/mL) PFS ◯ 1 vial (45mg/0.5mL)	**Starter Dose:** ◯ **Weight <60kg:** Inject _____mg (0.75mg/kg) SQ at weeks 0 and 4 ◯ **Weight 60-100kg:** Inject 45mg SQ at weeks 0 and 4 ◯ **Weight > 100kg:** Inject 90mg SQ at weeks 0 and 4	**1 Refill**
	◯ 1 carton (1x45mg/0.5mL) PFS ◯ 1 carton (1x90mg/mL) PFS ◯ 1 vial (45mg/0.5mL)	**Maintenance Dose:** ◯ **Weight < 60kg:** Inject _____mg (0.75mg/kg) SQ every 12 weeks ◯ **Weight 60-100kg:** Inject 45mg SQ every 12 weeks ◯ **Weight > 100kg:** Inject 90mg SQ every 12 weeks	

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.