


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
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.			
OMVOH™ PFS Pen	CD Package (1x200mg/2ml + 1x100mg/ml) UC Package (2x100mg/ml)	CD Maintenance Dose: Inject 300mg SQ every 4 weeks, starting at week 12 UC Maintenance Dose: Inject 200mg SQ every 4 weeks, starting at week 12	
	45mg tablets (28 day supply)	CD Starter Dose: Take 1 tablet by mouth daily for 12 weeks UC Starter Dose: Take 1 tablet by mouth daily for 8 weeks	2
RINVOQ®	15mg tablets (30 day supply) 30mg tablets (30 day supply)	Maintenance Dose: Take 1 tablet by mouth daily	1

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.