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Rheumatology Referral Form

Surescripts ID #: CPR10785350213549930
 Office: 1-888-292-0744
 Fax Referral #: **1-800-269-5493**

Referral Info

PATIENT INFORMATION

Patients Name:		SSN#:		DOB:	
Address:		City:		State:	
Home Phone:		Cell Phone:		Height:	
				Weight:	
Email Address:				Gender: Male Female	
				Diagnosis Code:	

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

<input type="checkbox"/> ACTEMRA®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> COSENTYX®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> BRIDGE* <input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> KEVZARA®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> HUMIRA® CITRATE-FREE	<input type="checkbox"/> STARTER PACK	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> STARTER PACK	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> OTEZLA®	<input type="checkbox"/> TITRATION PACK	<input type="checkbox"/> BRIDGE <input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> TALTZ®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE
<input type="checkbox"/> OLUMIANT®	<input type="checkbox"/> INDUCTION	<input type="checkbox"/> MAINTENANCE

*Covered Until You're Covered Program

INDUCTION STARTER		MAINTENANCE	
STRENGTH:		STRENGTH:	
SIG/DIRECTIONS		SIG/DIRECTIONS	
<input type="checkbox"/> AUTOINJECTOR <input type="checkbox"/> PEN <input type="checkbox"/> PREFILLED SYRINGE <input type="checkbox"/> VIAL		<input type="checkbox"/> AUTOINJECTOR <input type="checkbox"/> PEN <input type="checkbox"/> PREFILLED SYRINGE <input type="checkbox"/> VIAL	
QUANTITY:	REFILLS:	QUANTITY:	REFILLS:

Primary Diagnosis

Rheumatoid Arthritis Psoriatic Arthritis
 Other: _____
 Osteoporosis Forteo Prolia Other _____

Prior Treatment

Methotrexate Duration _____
 Cyclosporine Duration _____
 Sulfasalazine Duration _____
 Other Duration _____

OTB/PPD Test Negative? Yes No Date of Test: _____

Medical Justification for Prescribing Biologic Therapy (or attach history)

No reponse to previous treatment
 (list): _____
 Contraindications
 (list): _____
 Side effects, lab abnormalities, toxicity issues
 (list): _____

OTHER

STRENGTH:

SIG/DIRECTIONS

QUANTITY:

REFILLS:

PHYSICIAN INFORMATION

Injection Training: Office to Instruct SP to Arrange Teaching

Prescriber Name:		Phone:		Fax:	
Office Contact/Faxed By:		Email:			
NPI#:		TAX ID#:		Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office 1st Order Only <input type="checkbox"/> MD Office All Orders	
Prescriber Signature			Date:		
<input type="checkbox"/> Dispense as written					

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.

RxExpress 2-Day Ready 2 Ship:
 Receive all the benefits of our fast and easy express service, including our NEW 2-Day Ready 2 Ship, for all eligible prescriptions.

BioPlus Specialty Pharmacy
 376 Northlake Blvd., Altamonte Spings, FL 32701



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