BioPlus® Specialty Pharmacy
www.bioplusrx.com

Crohn's Disease/UC 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:	Zip:
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male Female
Email Address:			Diagnosis Code:	

INSURANCE INFORMATION (or attach copy of your cards)

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

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

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

Humira® Starter Pack: (CF=Citrate Free)
80mg / 0.8ml Pens CF
❑ 160mg SubQ Day 1 / 80mg SubQ Day 15
❑ 80mg SubQ Day 1/ 80mg SubQ Day 2/ 80mg SubQ Day 15
Qty: 1 Pack Refills: 0

Humira® Maintenance: ❑ Pen ❑ Prefilled Syringe (CF=Citrate Free)
40mg / 0.4ml CF
❑ 40mg SubQ Every Other Week
Qty: 28 Day Supply Refills:

Cimzia® Starter Kit:
❑ 2 x 200 mg Prefilled Syringe SubQ Weeks 0, 2, 4
Qty: 1 Pack Refills: 0

Cimzia® Maintenance Dosing: (❑Prefilled Syringe ❑Lypholized Powder)
❑ 2 x 200 mg SubQ Every 4 wks
❑ 1 x 200 mg SubQ Every 2 wks
Qty: 28 Day Supply Refills:

Remicade® Induction Dosing:
❑ 5 mg/kg (#_____100 mg vials)Intravenously Weeks 0, 2, 6

Remicade® Maintenance Dosing:
❑ 5 mg/kg (#_____100 mg vials)Intravenously Every 8 Wks
Refills:

Simponi® Induction Dosing:
❑ (❑ Prefilled Syringe ❑ SmartJect) 200mg (2 x 100mg) SubQ at week 0
Qty: 2 Syringes Refills: 0

Simponi® Maintenance Dosing:
❑ #1 (❑ Prefilled Syringe ❑ SmartJect) starting at week 2 of treatment, 100mg SubQ every 4 weeks
Qty: 1 Syringe Refills:

Entyvio® Induction Dosing:
❑ 300 mg Intravenously Weeks 0, 2, 6
Qty: 1 Refills: 2

Entyvio® Maintenance Dosing:
❑ 300 mg Intravenously Every 8 Weeks
Qty: Refills:

Stelara
❑ **IV Inductions:** ❑ 260mg (pt wght:<55kg) ❑ 390mg (pt wght: 55-85kg) ❑ 520mg (pt wght:>85kg)
Qty: 1 Refills:
❑ **Maintenance:** ❑ 90mg SubQ 8 weeks after IV induction dose then every 8 weeks
Qty: 1 Refills:

Xeljanz
❑ 5 mg by mouth twice daily
❑ 10 mg by mouth twice daily
Qty: Refills:

❑OTHER

STRENGTH:

SIG/DIRECTIONS

REFILLS: **QUANTITY:**

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
NPI#:	TAX ID#:	Deliver To: ❑MD Office ❑Patient Home
Prescriber Signature		
❑ Dispense as written	Date	

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.

*We will let you know within 2 hours if your patient can be admitted pending insurance qualification or non-admitted and triaged to another pharmacy. **V.BP110818**

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

2 HOURS