

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

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

Humira® Starter Pack: Citrate Free Pens
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:**

Humira® Maintenance: Citrate Free Pens
40mg / 0.4ml CF

40mg SubQ Every Other Week
Qty: 28 Day Supply **Refills:**

If PFS is preferred over pens, please check here: **Yes, PFS**

Cimzia® Starter Kit:

2 x 200 mg Prefilled Syringe SubQ Weeks 0, 2, 4
Qty: 1 Pack **Refills:**

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:**

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: **Refills:**

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: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient Home	
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Prescriber Signature		
<input type="checkbox"/> 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.BP011819**

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

