

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:

MEDICATIONS

<p>ACTEMRA®</p> <p><input type="checkbox"/> Maintenance: <input type="checkbox"/> 80mg/4ml <input type="checkbox"/> 200mg/10ml <input type="checkbox"/> 400mg/20ml <input type="checkbox"/> 162 mg/9ml Prefilled Syringe</p> <p><input type="checkbox"/> Infuse (<input type="checkbox"/> 4mg/kg <input type="checkbox"/> 8mg/kg) IV every 4 weeks</p> <p><input type="checkbox"/> Inject 162mg SQ (<input type="checkbox"/> QOW <input type="checkbox"/> QW) Qty: _____ Refills: _____</p> <p>COSENTYX™ *Covered Until You're Covered Program</p> <p><input type="checkbox"/> 150mg Sensoready® Pen Kit <input type="checkbox"/> 150mg Prefilled Syringe Kit</p> <p><input type="checkbox"/> Induction: Inject 300mg/ml SubQ week 0,1,2,3,4 Qty: 10 Refills: _____</p> <p><input type="checkbox"/> Maintenance: Inject 300mg SubQ every 4 weeks Qty: 28 days Refills: _____</p> <p><input type="checkbox"/> Bridge*</p> <p>CIMZIA® <input type="checkbox"/> Prefilled Syringe</p> <p><input type="checkbox"/> Induction: Inject 2 x 200mg/ml SubQ at week 1; inject 2 x 200mg/ml at week 2 and 4 Qty: _____ Refills: _____</p> <p><input type="checkbox"/> Maintenance: <input type="checkbox"/> 2 x 200mg SubQ Every 4 wks <input type="checkbox"/> 2 x 200mg SubQ Every 2 wks Qty: _____ Refills: _____</p> <p>ENBREL® <input type="checkbox"/> Mini Cartridge <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> SureClick Autoinjector <input type="checkbox"/> Vial</p> <p><input type="checkbox"/> Induction: Inject (50mg) SubQ twice weekly for three months Qty: 8 Refills: _____</p> <p>ENBREL® Maintenance Dose</p> <p><input type="checkbox"/> 50mg <input type="checkbox"/> 25mg <input type="checkbox"/> Once weekly SubQ <input type="checkbox"/> Twice weekly SubQ Qty: <input type="checkbox"/> 8 <input type="checkbox"/> 4 Refills: _____</p> <p>OLUMIANT® <input type="checkbox"/> 2mg tablets</p> <p><input type="checkbox"/> Maintenance: <input type="checkbox"/> Take one tablet by mouth daily Qty: _____ Refills: _____</p>	<p>HUMIRA® (CF=Citrate Free)</p> <p><input type="checkbox"/> 40mg Pens <input type="checkbox"/> 40mg Pens CF</p> <p>Maintenance: <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe</p> <p><input type="checkbox"/> 40mg SQ every other week <input type="checkbox"/> 40mg SQ once a week Qty: 28 days Refills: _____</p> <p>**If dosage form is not selected, PENS will be dispensed.**</p> <p>OTEZLA®</p> <p><input type="checkbox"/> Titration Pack: take by mouth as directed per package instructions Qty: 1 Pack Refills: 0</p> <p><input type="checkbox"/> Bridge Pack: take by mouth as directed per package instructions Qty: 1 Pack Refills: _____</p> <p><input type="checkbox"/> Maintenance: (30mg) by mouth twice daily Qty: 30 days Refills: _____</p> <p>TALTZ® <input type="checkbox"/> Autoinjector <input type="checkbox"/> Prefilled Syringe</p> <p><input type="checkbox"/> Psoriasis Induction: Inject 160mg (2 x 80mg injections) SubQ at week 0; Inject 80mg at weeks 2,4,6,8,10,12 Qty: 8 Refills: _____</p> <p><input type="checkbox"/> Psoriatic Arthritis Induction: Inject 160mg (2 x 80mg injections) SubQ at week 0 Qty: 2 Refills: _____</p> <p><input type="checkbox"/> Maintenance: 80mg SubQ every 4 weeks Qty: 1 Refills: _____</p> <p>XELJANZ® <input type="checkbox"/> 5mg tablet <input type="checkbox"/> 11mg Extended Release tabs</p> <p><input type="checkbox"/> Maintenance: Take one 5mg tablet by mouth twice daily <input type="checkbox"/> Maintenance: Take one 11mg tablet by mouth once daily Qty: _____ Refills: _____</p> <p>SIMPONI® <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Smartject</p> <p><input type="checkbox"/> Maintenance: Inject SQ once a month <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg Qty: 1 Refills: _____</p>	<p>KEVZARA® <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe</p> <p><input type="checkbox"/> 200mg <input type="checkbox"/> 150mg</p> <p>Maintenance: <input type="checkbox"/> Inject 200mg SQ once every 2 weeks <input type="checkbox"/> Inject 150mg SQ once every 2 weeks Qty: _____ Refills: _____</p> <p>Primary Diagnosis</p> <p><input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Osteoporosis <input type="checkbox"/> Forteo <input type="checkbox"/> Prolia <input type="checkbox"/> Other _____</p> <p>Primary Treatment</p> <p><input type="checkbox"/> Methotrexate <input type="checkbox"/> Duration _____ <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Duration _____ <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Duration _____ <input type="checkbox"/> Other <input type="checkbox"/> Duration _____</p> <p>OTB/PPD Test Negative? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Test: _____</p> <p>Medical Justification for Prescribing Biologic Therapy (or attach history) No response to previous treatment (list): _____ Contraindications (list): _____ Side effects, lab abnormalities, toxicity issues (list): _____</p> <p><input type="checkbox"/> OTHER</p> <p>STRENGTH:</p> <p>SIG/DIRECTIONS:</p> <p>QUANTITY: _____ REFILLS: _____</p>
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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

RxExpress
2-Day Ready 2 Ship

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