

## 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:

### PRIMARY DIAGNOSIS

Moderate to Severe Plaque Psoriasis  Psoriatic Arthritis  Hidradentis Suppurativa  Atopic Dermatitis  Other: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

### MEDICATIONS

**CIMZIA<sup>®</sup>**  Prefilled Syringe  
 **Induction:**  
 Inject 2x200mg/ml SubQ at week 0, 2 and 4  
 Qty: 6 syringes Refills:   
**CIMZIA<sup>®</sup> Maintenance Dose**  
 2 x 200mg SubQ Every 4 wks  
 2 x 200mg SubQ Every 2 wks  
 1 x 200mg SubQ Every 2 wks  
 Qty: 28 days Refills:

**COSENTYX<sup>™</sup>** \*Covered Until You're Covered Program  
 150mg Sensoready<sup>®</sup> Pen Kit  
 150mg Prefilled Syringe Kit  
 **Induction:** Inject 300mg/ml SubQ week 0,1,2,3,4  
 Qty: 10 Refills:   
 **Maintenance:** Inject 300mg SubQ every 4 weeks  
 Qty: 28 days Refills:   
 **Bridge\***

**DUPIXENT**  Prefilled Syringe  
 **Induction:** Inject 2x300mg (600mg) SubQ Day 1  
 Qty: 2 for 14 days Refills:   
 **Maintenance:** Inject 300mg SubQ every other week  
 Qty: 2 for 28 days Refills:

**ENBREL<sup>®</sup>**  Mini Cartridge  Prefilled Syringe  
 SureClick Autolinjector  Vial  
 **Induction:**  
 Inject (50mg) SubQ twice weekly for three months  
 Qty: 8 Refills:   
**ENBREL<sup>®</sup> Maintenance Dose**  
 50mg  25mg  
 Once weekly SubQ  Twice weekly SubQ  
 Qty:   Refills:

**HUMIRA<sup>®</sup>** (CF=Citrate Free)  
**Hidradentis Suppurativa Starter**  
 40mg/0.8ml Pens  80mg/0.8ml Pens CF  
 160mg SQ Day 1/ 80mg SQ Day 15  
 80mg SQ Day 1/ 80mg SQ Day 2/ 80mg SQ Day 15  
**Psoriasis Starter**  
 40mg/0.8ml Pens  80mg/0.8ml + 40mg/0.4ml Pens CF  
 80mg SQ Day 1/40mg SQ Day 8/40mg SQ Day 22  
 Qty: 1 Pack Refills:   
**Hidradentis Suppurativa Maintenance:**  Pen  Prefilled Syringe  
 40mg/0.8ml  40.mg/0.4ml CF  
 40mg SQ once weekly, beginning Day 29  
**Psoriasis Maintenance:**  Pen  Prefilled Syringe  
 40mg/0.8ml  40.mg/0.4ml CF  
 40mg SQ every other week  
 Qty: 28 days Refills:

**\*\*If dosage form is not selected, PENS will be dispensed.\*\***

**ILUMYA<sup>™</sup>**  Prefilled Syringe  
 Inject 100mg/ml SubQ at weeks 0,4 and every 12 weeks thereafter  
 Qty: 1 Refills:

**OTEZLA<sup>®</sup>**  
 **Titration Pack:** take by mouth as directed per package instructions  
 Qty: 1 Pack Refills:   
 **Bridge Pack:** take by mouth as directed per package instructions  
 Qty: 1 Pack Refills:   
 **Maintenance:** (30mg) by mouth twice daily  
 Qty: 30 days Refills:

**SIMPONI<sup>®</sup>**  Prefilled Syringe  Smartject Autoinjector  
 Inject 50mg SubQ once a month  
 Qty: 1 Refills:

**SILIQ<sup>™</sup>**  Prefilled Syringe  
 **Induction:** Inject 210mg SubQ weeks 0, 1, 2  
 Qty: 3 Refills:   
 **Maintenance:** Inject 210mg SubQ every two weeks  
 Qty: 2 Refills:

**STELARA<sup>®</sup>**  45mg Prefilled Syringe  90mg Prefilled Syringe  
 **Induction:** Inject contents of 1 syringe SubQ on Day 0 and Day 28  
 Qty: 1 syringe Refills:   
 **Maintenance:** Inject contents of 1 syringe SubQ every 12 weeks  
 Qty: 1 syringe Refills:

**TALTZ<sup>®</sup>**  Autolinjector  Prefilled Syringe  
 **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:   
 **Psoriatic Arthritis Induction:** Inject 160mg (2 x 80mg injections) SubQ at week 0  
 Qty: 2 Refills:   
 **Maintenance:** 80mg SubQ every 4 weeks  
 Qty: 1 Refills:

**TREMFYA<sup>™</sup>**  Prefilled Syringe  
 **Induction:** Inject 100mg SubQ weeks 0 and 4  
 Qty: 1 Refills:   
 **Maintenance:** Inject 100mg SubQ every 8 weeks  
 Qty: 1 Refills:

**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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