BioPlus® Specialty Pharmacy
www.bioplusrx.com

Dermatology 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:

PRIMARY DIAGNOSIS

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

MEDICATIONS

CIMZIA® ❑ Prefilled Syringe
❑ **Induction:**
Inject 2x200mg/ml SubQ at week 0, 2 and 4
Qty: 6 syringes **Refills:** 0
CIMZIA® 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™ *Covered Until You're Covered Program
❑ 150mg Sensoready® Pen Kit
❑ 150mg Prefilled Syringe Kit
❑ **Induction:** Inject 300mg/ml SubQ week 0,1,2,3,4
Qty: 10 **Refills:** 0
❑ **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® ❑ Mini Cartridge ❑ Prefilled Syringe
❑ SureClick AutoInjector ❑ Vial
❑ **Induction:**
Inject (50mg) SubQ twice weekly for three months
Qty: 8 **Refills:** 2
ENBREL® Maintenance Dose
❑ 50mg ❑ 25mg
❑ Once weekly SubQ ❑ Twice weekly SubQ
Qty: ❑ 8 ❑ 4 **Refills:**

HUMIRA® (CF=Citrate Free)
Hidradenitis 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:** 0
Hidradenitis 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™ ❑ Prefilled Syringe
❑ Inject 100mg/ml SubQ at weeks 0,4 and every 12 weeks thereafter
Qty: 1 **Refills:**

OTEZLA®
❑ **Titration Pack:** take by mouth as directed per package instructions
Qty: 1 Pack **Refills:** 0
❑ **Bridge Pack:** take by mouth as directed per package instructions
Qty: 1 Pack **Refills:**
❑ **Maintenance:** (30mg) by mouth twice daily
Qty: 30 days **Refills:**

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

SIMPONI® ❑ Prefilled Syringe ❑ Smartject Autoinjector
❑ Inject 50mg SubQ once a month
Qty: 1 **Refills:**

SKYRIZI™ ❑ Prefilled Syringe
❑ Inject 150mg (two 75 mg injections) SubQ at Week 0, Week 4 and every 12 weeks thereafter.
Qty: 1 **Refills:**

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

TALTZ® ❑ AutoInjector ❑ 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:** 0
❑ **Psoriatic Arthritis Induction:** Inject 160mg (2 x 80mg injections) SubQ at week 0
Qty: 2 **Refills:** 0
❑ **Maintenance:** 80mg SubQ every 4 weeks
Qty: 1 **Refills:**

TREMFYA™ ❑ Prefilled Syringe
❑ **Induction:** Inject 100mg SubQ weeks 0 and 4
Qty: 1 **Refills:** 1
❑ **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: ❑ Patient ❑ MD Office 1st Order Only ❑ MD Office All Orders
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.

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.

RxExpress 2-Day Ready 2 Ship

BioPlus Specialty Pharmacy
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