A CAREPATHrx Company
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Dermatology Referral Form

Surescripts ID #: CPR10785350213549930
Office: 1-888-292-0744
Fax Referral #: 1-800-269-5493

Referral Info

PATIENT INFORMATION

Patient's Name:	SSN:	DOB:
Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Height:	Weight:
Email Address:		Gender: Male Female	

INSURANCE INFORMATION (or attach a copy of cards)

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

CLINICAL INFORMATION

Primary Diagnosis: ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa ☐ Atopic Dermatitis ☐ Other: ____________ **Diagnosis Code(ICD-10):**____________

Date of Diagnosis:	TB Test Completed On:	BSA:	Latex Allergy: Y N

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

Cimzia® (certolizumab pegol) Prefilled Syringe
☐ **Induction:** Inject 2 x 200 mg/ ml SubQ at week 0, 2 and 4
Qty: 6 syringes **Refills:** 0
Maintenance:
☐ 2 x 200 mg SubQ every 4 wks
☐ 2 x 200 mg SubQ every 2 wks
☐ 200 mg SubQ every 2 wks
Qty: 28 days **Refills:** ____

COSENTYX™ (secukinumab)
☐ 150 mg Sensoready® Pen Kit
☐ 150 mg Prefilled Syringe Kit
Induction:
☐ Inject 300 mg (2 x 150 mg/ ml) SubQ week 0, 1, 2, 3, 4
Qty: 10 Refills: 0
☐ Inject 150 mg SubQ week 0, 1, 2, 3, 4
Qty: 5 **Refills:** ____
Maintenance:
☐ Inject 300 mg SubQ every 4 weeks
☐ Inject 150 mg SubQ every 4 weeks
Qty: 28 days **Refills:** ____
☐ **Bridge***

DUPIXENT® (dupilumab) ☐ Prefilled Syringe ☐ Pen
☐ **Induction:** Inject 2 x 300 mg (600 mg) SubQ Day 1
Qty: 2 for 14 days **Refills:** ____
☐ **Maintenance:** Inject 300 mg SubQ every other week
Qty: 2 for 28 days **Refills:** ____

ENBREL® (etanercept)
☐ Mini Cartridge ☐ Prefilled Syringe
☐ SureClick AutoInjector ☐ Vial
☐ **Induction:** Inject (50 mg) SubQ twice weekly for three months
Qty: 8 **Refills:** 2
Maintenance:
☐ 50 mg ☐ 25 mg
☐ Once weekly SubQ ☐Twice weekly SubQ
Qty: ☐ 8 ☐ 4 **Refills:** ____

HUMIRA® (adalimumab)
☐ Pen ☐ Prefilled Syringe
☐ Citrate Free(CF) ☐ Original Formula
Hidradenitis Suppurativa Starter:
☐ 160 mg SubQ Day 1/ 80 mg SubQ Day 15
☐ 80 mg SubQ Day 1/ 80 mg SubQ Day 2/ 80 mg SubQ Day 15
☐ ***Psoriasis Starter:***
80 mg SubQ Day 1, 40 mg SubQ Day 8, 40 mg SubQ Day 22
Qty: 1 Pack **Refills:** 0
☐***Hidradenitis Suppurativa Maintenance:***
☐ 40 mg SubQ once weekly, beginning Day 29
☐ 80 mg SubQ every other week, beginning Day 29
☐ ***Psoriasis Maintenance:***
40 mg SubQ every other week
Qty: 28 days **Refills:** ____

INFLECTRA® (infliximab-dyyb) 100 mg vials
☐3 mg/ kg ☐ 5 mg/ kg ☐ 10 mg/ kg
☐ **Induction:** Give dose as an IV infusion at 0, 2, and 6 weeks
Qty: ____ **Refills:** 2
☐**Maintenance:** Give dose as an IV infusion every __ weeks
Qty: ____ **Refills:** 2

ILUMYA™ (tildrakizumab-asmn) ☐ Prefilled Syringe
☐ Inject 100 mg/ml SubQ at weeks 0, 4 and every 12 weeks thereafter
Qty: 1 **Refills:**

OTEZLA® (apremilast)
☐ **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:** (30 mg) by mouth twice daily
Qty: 30 days **Refills:** ____

REMICADE® (infliximab-dyyb) 100 mg vials
☐ **Induction:** 5 mg/ kg as an IV infusion at 0, 2, and 6 weeks
Qty: 1 dose Refills: 2
☐**Maintenance:** 5 mg/ kg as an IV infusion every 8 weeks
Qty: ____ **Refills:** ____

SILIQ® (brodalumab) Prefilled Syringe
☐ **Induction:** Inject 210 mg SubQ weeks 0 and 1
Qty: 2 **Refills:** 0
☐ **Maintenance:** Starting at Week 2 of therapy, inject 210 mg SubQ every two weeks
Qty: 2 **Refills:** ____

SIMPONI® (golimumab)
☐ Prefilled Syringe ☐Smartject Autoinjector
☐ Inject 50 mg SubQ once a month
Qty: 1 **Refills:** ____

SKYRIZI™ (risankizumab-rzaa) Prefilled Syringe
☐ Inject 150 mg (2 x 75 mg injections) SubQ at Week 0, Week 4, and every 12 weeks thereafter.
Qty: 2 syringes **Refills:** ____

STELARA® (ustekinumab)
☐ 45 mg Prefilled Syringe ☐ 90 mg 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® (ixekizumab) ☐ AutoInjector ☐ Prefilled Syringe
☐ ***Psoriasis Induction:*** Inject 160 mg (2 x 80 mg) SubQ at week 0; Inject 80 mg at weeks 2, 4, 6, 8, 10, 12
Qty: 8 **Refills:** 0
☐ ***Psoriatic Arthritis Induction:*** Inject 160 mg (2 x 80 mg) SubQ at week 0
Qty: 2 **Refills:**0
☐ **Maintenance:** 80 mg SubQ every 4 weeks
Qty: 1 **Refills:** ____

TREMFYA® (guselkumab)
☐ Prefilled Syringe ☐ One-Press Autoinjctor
☐ **Induction:** Inject 100 mg SubQ weeks 0 and 4
Qty: 1 **Refills:** 1
☐ **Maintenance:** Inject 100 mg SubQ every 8 weeks
Qty: 1 **Refills:** ____

OTHER	STRENGTH:	SIG/DIRECTIONS:	REFILLS:	QUANTITY:

As required by your state, Prescriber to check “Dispense as written” or handwrite “Brand Medically Necessary” and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

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

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	Ship To: ☐ Patient ☐ MD Office

NPI #:	Tax ID #:

Prescriber Signature: Date:

Your signature authorizes BioPlus Specialty Pharmacy Services, LLC, and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, and Route 300 Pharmacy (the “BioPlus Pharmacies”), 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.

BioPlus Specialty Pharmacy 376 Northlake Blvd., Altamonte Springs, FL 32701 **BioPlus Specialty Pharmacy** 100 Southcenter Ct. Suite 100, Morrisville, NC 27560
MedScripts Medical Pharmacy 1325 Miller Rd. Suite K, Greenville, SC 29607 **River Medical Pharmacy** 4752 Research Drive, San Antonio, TX 78240
Route 300 Pharmacy 1208 Route 300 Suite 103, Newburgh, NY 12550

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