E-prescribe the *Fast & Easy* way: select **BioPlus Specialty Pharmacy** from your EHR!

BioPlus® Specialty Pharmacy
A CAREPATHrx Company

Rheumatology Referral Form

Fax: 800-269-5493
Phone: 888-292-0744
bioplusrx.com

PATIENT INFORMATION

Patient Name:	SSN:		DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	Gender: ☐ Male ☐ Female

CLINICAL INFORMATION

Diagnosis: ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Juvenile Rheumatoid Arthritis ☐ Iridocyclitis (Uveitis) ☐ Other:_____

Allergies: | Weight: | Height:

TB Test Result: | Date: | HepB Test Result: | Date:

Prior Failed Meds: ☐ Actemra® ☐ Cosentyx® ☐ Cimzia® ☐ Enbrel® ☐ Humira® ☐ Kevzara® ☐ Orencia® ☐ Otezla® ☐ Other: _____

Prior Methotrexate/Oral Systemic Medications: ☐ Yes ☐ No ☐ Contraindicated

INSURANCE INFORMATION *(or attach copy of cards)*

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

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

ACTEMRA® (tocilizumab)
Maintenance: ☐ 80 mg/ 4 ml ☐ 200 mg/ 10 ml
☐ 400 mg/ 20 ml ☐ 162 mg/ 0.9 ml prefilled syringe
☐ 162 mg/ 0.9 ml ACTPen
☐ **Infuse** (☐ 4 mg/ kg ☐ 8 mg/ kg) IV every 4 weeks
☐ **Inject** 162 mg SubQ (☐ QOW ☐ QW)
Qty: Refills:

CIMZIA® (certolizumab pegol) ☐ Prefilled Syringe
☐ **Induction:** Inject 400 mg (2 x 200 mg/ ml) SubQ at weeks 0, 2, and 4
Qty: 6 Refills:
☐ **Maintenance:**
☐ 400 mg (2 x 200 mg) SubQ every 4 wks
☐ 400 mg (2 x 200 mg) SubQ every 2 wks
☐ 200 mg SubQ every 2 wks
Qty: Refills:

COSENTYX™ (secukinumab)
☐ 150 mg Sensoready® Pen Kit
☐ 75 mg PFS ☐ 150 mg PFS
☐ 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:

ENBREL® (etanercept) ☐ Mini Cartridge
☐ Prefilled Syringe
☐ SureClick AutoInjector ☐ Vial
☐ 50 mg ☐ 25 mg
☐ Once weekly SubQ ☐ Twice weekly SubQ
Qty: ☐ 4 ☐ 8 Refills:

HUMIRA®(adalimumab)
☐ Pen ☐ Prefilled Syringe
☐ Citrate Free(CF) ☐ Original Formula
☐ 40 mg SubQ every other week
☐ 40 mg SubQ once a 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:
☐**Maintenance:** Give dose as an IV infusion every __ weeks
Qty: Refills:

KEVZARA® (sarilumab) ☐ Pen ☐ Prefilled Syringe
☐ 150 mg ☐ 200 mg
Dosing: Inject SubQ every 2 weeks.
Qty: 2 Refills:

ORENCIA® (abatacept) ☐ 125 mg Prefilled Syringe
☐ 250 mg Vial ☐ 125 mg auto-injector
Dosing:
☐ Inject 125 mg SubQ once a week.
☐ Infuse ___mg IV at Weeks 0, 2, and 4 then, every 4 weeks
Qty: 4 week supply Refills:

OLUMIANT® (baricitinib) ☐ 1 mg tablet ☐ 2 mg tablet
☐ Take 1 tablet by mouth daily
Qty: 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: 0
☐ **Maintenance:** 30 mg by mouth twice daily
Qty: 30 days Refills:

REMICADE® (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:

RINVOQ® (upadacitinib)
☐ 15 mg by mouth daily
Qty: Refills:

SIMPONI® (golimumab) 50 mg
☐ Prefilled Syringe ☐SmartJect
Inject SubQ once a month
Qty: 1 Refills:

STELARA® (ustekinumab)
☐ 45 mg Prefilled Syringe ☐ 90 mg Prefilled Syringe
Inject contents of 1 syringe SubQ on day 0, then week 4, then every 12 weeks
Qty: 1 Refills:

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

XELJANZ® (tofacitinib)
☐ 5 mg tablet ☐ 11 mg XR tabs
☐ Take one 5 mg tablet by mouth twice daily
☐ Take one 11 mg tablet by mouth once daily
Qty: Refills:

OTHER

STRENGTH:

SIG/DIRECTIONS:

QUANTITY: **REFILLS:**

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:	
Address:		
NPI #:	Tax ID #:	
Prescriber Signature:		Date:

BioPlus Specialty Pharmacy 376 Northlake Blvd., Altamonte Springs, FL 32701 **BioPlus Specialty Pharmacy** 100 Southcenter Ct. Suite 100, Morrisville, NC 27560
BioPlus Specialty Pharmacy 13925 Yale Ave Ste 145 Irvine, CA 92620 **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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