



A CAREPATHrx Company

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

Dermatology Referral Form

Fax: 800-269-5493

Phone: 888-292-0744
bioplusrx.com

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 copy of cards)

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

<p>Cimzia® (certolizumab pegol) Prefilled Syringe <input type="checkbox"/> Induction: Inject 2 x 200 mg/ml SubQ at week 0, 2 and 4 Qty: 6 syringes Refills: 0 Maintenance: <input type="checkbox"/> 2 x 200 mg SubQ every 4 wks <input type="checkbox"/> 2 x 200 mg SubQ every 2 wks <input type="checkbox"/> 200 mg SubQ every 2 wks Qty: 28 days Refills: _____</p> <p>COSENTYX™ (secukinumab) <input type="checkbox"/> 150 mg Sensoready® Pen Kit <input type="checkbox"/> 75 mg Prefilled Syringe Kit <input type="checkbox"/> 150 mg Prefilled Syringe Kit Induction: <input type="checkbox"/> Inject 300 mg (2 x 150 mg/ml) SubQ week 0, 1, 2, 3, 4 Qty: 10 Refills: 0 <input type="checkbox"/> Inject 150 mg SubQ week 0, 1, 2, 3, 4 Qty: 5 Refills: _____ Maintenance: <input type="checkbox"/> Inject 300 mg SubQ every 4 weeks <input type="checkbox"/> Inject 150 mg SubQ every 4 weeks Qty: 28 days Refills: _____ <input type="checkbox"/> Bridge*</p> <p>DUPIXENT® (dupilumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Induction: Inject 2 x 300 mg (600 mg) SubQ Day 1 Qty: 2 for 14 days Refills: _____ <input type="checkbox"/> Maintenance: Inject 300 mg SubQ every other week Qty: 2 for 28 days Refills: _____</p> <p>ENBREL® (etanercept) <input type="checkbox"/> Mini Cartridge <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> SureClick Autoinjector <input type="checkbox"/> Vial <input type="checkbox"/> Induction: Inject (50 mg) SubQ twice weekly for three months Qty: 8 Refills: 2 Maintenance: <input type="checkbox"/> 50 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> Once weekly SubQ <input type="checkbox"/> Twice weekly SubQ Qty: <input type="checkbox"/> 8 <input type="checkbox"/> 4 Refills: _____</p>	<p>HUMIRA® (adalimumab) <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Citrate Free(CF) <input type="checkbox"/> Original Formula Hidradenitis Suppurativa Starter: <input type="checkbox"/> 160 mg SubQ Day 1/ 80 mg SubQ Day 15 <input type="checkbox"/> 80 mg SubQ Day 1/ 80 mg SubQ Day 2/ 80 mg SubQ Day 15 <input type="checkbox"/> Psoriasis Starter: <input type="checkbox"/> 80 mg SubQ Day 1, 40 mg SubQ Day 8, 40 mg SubQ Day 22 Qty: 1 Pack Refills: 0 <input type="checkbox"/> Hidradenitis Suppurativa Maintenance: <input type="checkbox"/> 40 mg SubQ once weekly, beginning Day 29 <input type="checkbox"/> 80 mg SubQ every other week, beginning Day 29 <input type="checkbox"/> Psoriasis Maintenance: <input type="checkbox"/> 40 mg SubQ every other week Qty: 28 days Refills: _____</p> <p>INFLECTRA® (infliximab-dyyb) 100 mg vials <input type="checkbox"/> 3 mg/kg <input type="checkbox"/> 5 mg/kg <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> Induction: Give dose as an IV infusion at 0, 2, and 6 weeks Qty: _____ Refills: 2 <input type="checkbox"/> Maintenance: Give dose as an IV infusion every ___ weeks Qty: _____ Refills: 2</p> <p>ILUMYA™ (tildrakizumab-asmn) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Inject 100 mg/ml SubQ at weeks 0, 4 and every 12 weeks thereafter Qty: 1 Refills: _____</p> <p>OTEZLA® (apremilast) <input type="checkbox"/> Titration Pack: Take by mouth as directed per package instructions Qty: 1 Pack Refills: 0 <input type="checkbox"/> Bridge Pack: Take by mouth as directed per package instructions Qty: 1 Pack Refills: _____ <input type="checkbox"/> Maintenance: (30 mg) by mouth twice daily Qty: 30 days Refills: _____</p> <p>REMICADE® (infliximab-dyyb) 100 mg vials <input type="checkbox"/> Induction: 5 mg/kg as an IV infusion at 0, 2, and 6 weeks Qty: 1 dose Refills: 2 <input type="checkbox"/> Maintenance: 5 mg/kg as an IV infusion every 8 weeks Qty: _____ Refills: _____</p>	<p>SILIQ® (brodalumab) Prefilled Syringe <input type="checkbox"/> Induction: Inject 210 mg SubQ weeks 0 and 1 Qty: 2 Refills: 0 <input type="checkbox"/> Maintenance: Starting at Week 2 of therapy, inject 210 mg SubQ every two weeks Qty: 2 Refills: _____</p> <p>SIMPONI® (golimumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Smartject Autoinjector <input type="checkbox"/> Inject 50 mg SubQ once a month Qty: 1 Refills: _____</p> <p>SKYRIZI™ (risankizumab-rzaa) Single Injection per dose <input type="checkbox"/> 150 mg/ml Prefilled Syringe <input type="checkbox"/> 150 mg/ml PEN <input type="checkbox"/> Inject 150 mg SubQ at Week 0, Week 4, and every 12 weeks thereafter. Qty: 1 Refills: _____</p> <p>STELARA® (ustekinumab) <input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe <input type="checkbox"/> Induction: Inject contents of 1 syringe SubQ on Day 0 and Day 28 Qty: 1 syringe Refills: 1 <input type="checkbox"/> Maintenance: Inject contents of 1 syringe SubQ every 12 weeks Qty: 1 syringe Refills: _____</p> <p>TALTZ® (ixekizumab) <input type="checkbox"/> Autoinjector <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 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 <input type="checkbox"/> Psoriatic Arthritis Induction: Inject 160 mg (2 x 80 mg) SubQ at week 0 Qty: 2 Refills: 0 <input type="checkbox"/> Maintenance: 80 mg SubQ every 4 weeks Qty: 1 Refills: _____</p> <p>TREMFYA® (guselkumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> One-Press Autoinjector <input type="checkbox"/> Induction: Inject 100 mg SubQ weeks 0 and 4 Qty: 1 Refills: 1 <input type="checkbox"/> Maintenance: Inject 100 mg SubQ every 8 weeks Qty: 1 Refills: _____</p>
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OTHER	STRENGTH:	SIG/DIRECTIONS:	REFILLS:	QUANTITY:
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As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:	Injection Training: _____	Office to Instruct _____	SP to Arrange Teaching _____
Office Contact:	Email:				
Address:					
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 copy 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
 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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