BioPlus® Specialty Pharmacy
A CAREPATHrx Company

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

RHEUMATOLOGY REFERRAL FORM

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

Patient Name:	SSN:		DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell:	Email:	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 INFORMATON (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the 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 Pen
☐ **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 Pen
☐ 75 mg Prefilled Syringe☐ 150 mg Prefilled Syringe
☐ 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***

ENBREL® *(etanercept)*
☐ Mini Cartridge ☐ Prefilled Syringe
☐ 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 autoinjector
☐ 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) extended-release tablets
☐ 15 mg ☐ 30 mg
Once daily PO with or without food
Qty:_____ **Refills:**_____

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

SKYRIZI™ (risankizumab-rzaa)
☐ Prefilled Syringe ☐ Pen
☐ Inject 150 mg(1 injection) SubQ at Week 0, Week 4, and every 12 weeks thereafter.
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:**_____

TREMFYA® *(guselkumab)*
☐ Prefilled Syringe ☐ Autoinjector
☐ **Induction:** Inject 100 mg SubQ weeks 0 and 4
Qty: 1 **Refills:** 1
☐ **Maintenance:** Inject 100 mg SubQ every 8 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:		Ship To: ☐ Patient ☐ MD Office
NPI #:	Tax ID#:	
Prescription Signature:		Date:

BioPlus Specialty Pharmacy 376 Northlake Blvd., Altamonte Springs, FL 32701
BioPlus Specialty Pharmacy 13925 Yale Ave, Suite145, Irvine, CA 92620
River Medical Pharmacy 4752 Research Drive, San Antonio, TX 78240
BioPlus Specialty Pharmacy 100 Southcenter Ct. Suite 100, Morrisville, NC 27560
MedScripts Medical Pharmacy 1325 Miller Rd. Suite K, Greenville, SC 29607
Route 300 Pharmacy 1208 Route 300 Suite 103, Newburgh, NY 12550

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