BioPlus Specialty Pharmacy
A CAREPATH 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)* 100 mg vials ☐ Biosimilar authorized
☐ 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
☐ **Induction:** Inject 150 mg(1 injection) SubQ at Week 0, Week 4
**Qty:** 2 **Refills: None**
☐ **Maintenance:** Inject 150 mg(1 injection) SubQ every 12 weeks
**Qty:** **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®** CF*(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 PO twice daily
☐ Take one 11 mg tablet by PO 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
Santa Barbara Specialty Pharmacy 4690 Carpinteria Ave, Ste B, Carpinteria, CA 93013
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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