

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 INFORMATION (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)

<p>ACTEMRA® (tocilizumab) Maintenance: <input type="checkbox"/> 80 mg/ 4 ml <input type="checkbox"/> 200 mg/ 10 ml <input type="checkbox"/> 400 mg/ 20 ml <input type="checkbox"/> 162 mg/ 0.9 ml prefilled syringe <input type="checkbox"/> 162 mg/ 0.9 ml Pen <input type="checkbox"/> Infuse (<input type="checkbox"/> 4 mg/ kg <input type="checkbox"/> 8 mg/ kg) IV every 4 weeks <input type="checkbox"/> Inject 162 mg SubQ (<input type="checkbox"/> QOW <input type="checkbox"/> QW) Qty: _____ 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: _____ <input type="checkbox"/> Maintenance: Give dose as an IV infusion every ___ weeks Qty: _____ Refills: _____</p>	<p>SKYRIZI™ (risankizumab-rzaa) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Induction: Inject 150 mg(1 injection) SubQ at Week 0, Week 4 Qty: 2 Refills: None <input type="checkbox"/> Maintenance: Inject 150 mg(1 injection) SubQ every 12 weeks Qty: _____ Refills: _____</p>
<p>CIMZIA® (certolizumab pegol) Prefilled Syringe <input type="checkbox"/> Induction: Inject 400 mg (2 x 200 mg/ ml) SubQ at weeks 0, 2, and 4 Qty: 6 Refills: _____ Maintenance: <input type="checkbox"/> 400 mg (2 x 200 mg) SubQ every 4 wks <input type="checkbox"/> 400 mg (2 x 200 mg) SubQ every 2 wks <input type="checkbox"/> 200 mg SubQ every 2 wks Qty: _____ Refills: _____</p>	<p>KEVZARA® (sarilumab) <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg Dosing: Inject SubQ every 2 weeks. Qty: 2 Refills: _____</p>	<p>STELARA® (ustekinumab) <input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe Inject contents of 1 syringe SubQ on day 0, then week 4, then every 12 weeks Qty: 1 Refills: _____</p>
<p>COSENTYX™ (secukinumab) <input type="checkbox"/> 150 mg Pen <input type="checkbox"/> 75 mg Prefilled Syringe <input type="checkbox"/> 150 mg Prefilled Syringe <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>ORENCIA® (abatacept) <input type="checkbox"/> 125 mg Prefilled Syringe <input type="checkbox"/> 250 mg vial <input type="checkbox"/> 125 mg autoinjector <input type="checkbox"/> Inject 125 mg SubQ once a week. <input type="checkbox"/> Infuse ___mg IV at Weeks 0, 2, and 4 then, every 4 weeks Qty: 4 week supply Refills: _____</p>	<p>TALTZ® CF (ixekizumab) <input type="checkbox"/> Autoinjector <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 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: _____ <input type="checkbox"/> Psoriatic Arthritis Induction: Inject 160 mg (2 x 80 mg injections) SubQ at week 0 Qty: 2 Refills: 0 <input type="checkbox"/> Maintenance: 80 mg SubQ every 4 weeks Qty: 1 Refills: _____</p>
<p>ENBREL® (etanercept) <input type="checkbox"/> Mini Cartridge <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector <input type="checkbox"/> Vial <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"/> 4 <input type="checkbox"/> 8 Refills: _____</p>	<p>OLUMIANT® (baricitinib) <input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2 mg tablet <input type="checkbox"/> Take 1 tablet by mouth daily Qty: _____ Refills: _____</p>	<p>TREMFYA® (guselkumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 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>
<p>HUMIRA® (adalimumab) <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Citrate Free(CF) <input type="checkbox"/> Original Formula <input type="checkbox"/> 40 mg SubQ every other week <input type="checkbox"/> 40 mg SubQ once a week Qty: 28 days 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: 0 <input type="checkbox"/> Maintenance: 30 mg by mouth twice daily Qty: 30 days Refills: _____</p>	<p>XELJANZ® (tofacitinib) <input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 11 mg XR tabs <input type="checkbox"/> Take one 5 mg tablet PO twice daily <input type="checkbox"/> Take one 11 mg tablet by PO once daily Qty: _____ Refills: _____</p>
<p>REMICADE® (infliximab) 100 mg vials <input type="checkbox"/> Biosimilar authorized <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: _____</p>	<p>RINVOQ® (upadacitinib) extended-release tablets <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg Once daily PO with or without food Qty: _____ Refills: _____</p>	<p>OTHER</p> <p>STRENGTH:</p> <p>SIG/DIRECTIONS:</p> <p>QUANTITY: _____ REFILLS: _____</p>
<p>SIMPONI® (golimumab) 50 mg <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector Inject SubQ once a month Qty: 1 Refills: _____</p>		

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:	<input type="checkbox"/> Patient <input type="checkbox"/> MD Office
NPI #:	Tax ID#:	
Prescription Signature:	Date:	

Your signature authorizes BioPlus Specialty Pharmacy Services, LLC, and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, Route 300 Pharmacy, and Santa Barbara Specialty 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 13925 Yale Ave, Suite 145, 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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