BioPlus® Specialty Pharmacy
A Carelon Company

E-prescribe the *Fast & Easy* way: select **BioPlus** from your EHR!
Fax: 800-269-5493
Phone: 888-292-0744
bioplusrx.com

CROHN'S/ UC REFERRAL FORM

PATIENT INFORMATION

Patient's Name:		SSN:		DOB:
Address:		City:	State:	Zip:
Home Phone:	Cell:	Height:	Weight:	Gender: ○ Male ○ Female
Email		Diagnosis Code:		

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)

AMJEVITA™ *(adalimumab-atto)*
☐ SureClick 40 mg/0.8 mL ☐ Prefilled Syringe 20 mg/0.4 mL ☐ Prefilled Syringe 40 mg/0.8 mL
Induction: 160 mg SubQ Day 1
☐ 4 x 40 mg SubQ in one day ☐ 2 x 40 mg SubQ per day for two consecutive days
☐ 2 x 40 mg SubQ Day 15
Qty: 6 **Refills:** 0
Maintenance:
☐ 40 mg SubQ every other week
Qty: ____ **Refills:** ____

CIMZIA® *(certolizumab pegol)*
☐ Prefilled Syringe ☐ Lyophilized Powder
☐ **Induction**: 400 mg (2 x 200 mg) SubQ weeks 0, 2, 4
Qty: 28 day supply **Refills**:0
Maintenance:
☐ 2 x 200 mg SubQ every 4 weeks
☐ 2 x 200 mg SubQ every 2 weeks
☐ 200 mg SubQ every 2 weeks
Qty: 28 day supply **Refills:** ____

DUPIXENT® *(dupilumab)*
☐ Prefilled Syringe ☐ Pen
☐ **Induction:** Inject 2 x 300 mg (600 mg) SubQ Day 1
Qty: 2 for 14 days **Refills:** None
☐ **Maintenance:** Inject 300 mg SubQ every other week
Qty: 2 for 28 days **Refills:** ____

Entocort® *(budesonide)*
3 mg capsules
☐ 9 mg PO daily
Qty: 90 **Refills**: ____

HUMIRA® *(adalimumab)*
☐ Pen ☐ Prefilled Syringe
☐ Citrate Free (CF) ☐ Original Formula
Induction:
☐ 160 mg SubQ day 1, 80 mg SubQ day 15
☐ 80 mg SubQ day 1, 80 mg SubQ day 2/ 80 mg SubQ day 15
Qty: 1 pack **Refills:** 0
☐ **Maintenance:**
40 mg SubQ every other week
Qty: 28 day supply **Refills:** ____
**** If dosage form is not selected, PENS will be dispensed.****

RINVOQ® *(upadacitinib)* extended-release tablets
☐ 15 mg ☐ 30 mg ☐ 45 mg
Induction:
☐ 45 mg PO once daily for 8 weeks ☐ 45 mg PO once daily for 12 weeks
Qty: 2 bottles **Refills:** 0
☐ **Maintenance:**_____ mg once daily
Qty: ____ **Refills:** ____

SIMPONI® *(golimumab)*
☐ Prefilled Syringe ☐ Autoinjector
☐ **Induction:** 200 mg (2 x 100 mg) SubQ at week 0
Qty: 2 syringes **Refills**: 0

SKYRIZI™ *(risankizumab-rzaa)*
☐ OBI ☐ VIAL
☐ **Induction:** 600 mg intravenously weeks 0, 4, 8
Qty: 1 **Refills**: 0
☐ **Maintenance:**
☐ 180 mg SubQ week12, then every 8 weeks
☐ 360 mg SubQ week12, then every 8 weeks
Qty:1 **Refills:** ____

STELARA® *(ustekinumab)*
☐ **IV Induction:** ☐ 260 mg (pt weight: ≤ 55 kg) ☐ 390 mg (pt weight: 56-85 kg)
☐ 520 mg (pt weight: >85 kg)
Qty: ____ **Refills:** 0
☐ **Maintenance:** Starting 8 weeks after IV induction dose, 90 mg SubQ every 8 weeks
Qty: 1

SOLESTA® *(dextranomer and sodium hyaluronate)* 1 ml Prefilled Syringe
☐ 4 submucosal injections
Qty: 4 **Refills:** ____

UCERIS® *(budesonide)* 9 mg Extended-Release Tablet
☐ 9 mg PO daily
Qty: 30 **Refills:** ____

XELJANZ® *(tofacitinib)*
☐ **Induction:** 10 mg PO twice daily for 8-16 week
Qty: ____ **Refills:** ____
☐ **Maintenance:** 5 mg PO twice daily
Qty: 60 **Refills:** ____

XIFAXAN® *(rifaximin)* ☐ 200 mg tablet ☐ 550 mg tablet
☐ 550 mg PO three times per day for 14 days
☐ 200 mg PO three times per day for 16 days
☐ ____ mg PO ____times per day for _____ days
Qty:____ **Refills:** ____

ZEPOSIA® *(ozanimod)*
☐ 7-day titration: days 1-4: Give 0.23 mg PO once daily. days 5 to 7: Give 0.46 mg PO daily
Qty: 1 **Refills:** None
☐ **Maintenance Dosing:** Starting day 8, 0.92 mg PO once daily
Qty: 30 Refills: **Refills**: ____

IMMUNOSUPPRESSIVE INFUSION ☐ **Biosimilar authorized**
☐ **AVSOLA®** ☐ **ENTYVIO®** ☐ **INFLECTRA®** ☐ **Infliximab** ☐ **REMICADE®** ☐ **RENFLEXIS®**
☐ **Initial Dose:** _____mg/kg at week 0, 2, and 6 ☐ **Maintenance Dose:** _____mg/kg every 8 weeks
☐ **Other:**_____mg/kg every _____ weeks **Refills:**_____

☐ OTHER	STRENGTH:	SIG/DIRECTIONS:	REFILLS:	QUANTITY:

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 Pharacy 376 Northlake Blvd., Altamonte Springs, FL 32701 **BioPlus Specialty Pharmacy** 100 Southcenter Ct., Suite 100, Morrisville, NC 27560
BioPlus Specialty Pharmacy 13925 Yale Ave, Suite145, 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
Santa Barbara Specialty Pharmacy 4690 Carpinteria Ave, Ste B, Carpinteria, CA 93013

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