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

DERMATOLOGY REFERRAL FORM

PATIENT INFORMATION

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

INSURANCE INFORMATION (or attach copy of the cards)

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

CLINICAL INFORMATION

Primary Diagnosis: ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa ☐ Atopic Dermatitis ☐ Alopecia Areata ☐ 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 the prescription)

ADBRY™ *(tralokinumab-ldrm)* 150 mg Prefilled Syringe
☐ **Induction:** Inject 600 mg (4x150 mg) SubQ
Qty: 4 **Refills:** None
Maintenance:
☐ Inject 300 mg (2 x150 mg) SubQ every other week
☐ Inject 300 mg (2 x150 mg) SubQ every 4 weeks
☐ **ADBRY™ Bridge Care™** Program:
Inject 300 mg (2 x 150 mg) SubQ every other week starting on Day 15
Qty: ☐ **Refills:**

AMJEVITA™ *(adalimumab-atto)* Prefilled Syringe
☐ SureClick 40 mg/0.8 mL ☐ Prefilled Syringe 20 mg/0.4 mL
☐ Prefilled Syringe 40 mg/0.8 mL
☐ **Induction:** Inject 2 x 40 mg SubQ
Maintenance:
☐ 40 mg every other week starting one week after initial dose
Qty: ☐ **Refills:**

CIBINQO™ (*abrocitinib*) Tablet
☐ 50 mg ☐ 100 mg ☐ 200 mg
_____ mg PO once daily
Qty: ☐ **Refills:**

Cimzia® (*certolizumab pegol*) Prefilled Syringe
☐ **Induction:** Inject 2 x 200 mg/ ml SubQ at week 0, 2, and 4
Qty: 6 syringes **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 days **Refills:**

COSENTYX® *(secukinumab)* ☐ 150 mg Sensoready® Pen Kit
☐ 75 mg Prefilled Syringe Kit ☐ 150 mg Prefilled Syringe Kit
Induction:
☐ 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***

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:**

ENBREL® *(etanercept)*
☐ Mini Cartridge ☐ Prefilled Syringe ☐ AutoInjector ☐ Vial
☐ **Induction:** Inject (50 mg) SubQ twice weekly for three months
Qty: 8 **Refills:** 2
Maintenance:
☐ 50 mg ☐ 25 mg
☐ Once weekly SubQ ☐ Twice weekly SubQ
Qty: ☐ 8 ☐ 4 **Refills:**

ERIVEDGE™ (*vismodegib*) capsule 150 mg Once daily PO with or without food
Qty: 28 days **Refills:**

HUMIRA® (*adalimumab*)
☐ Pen ☐ Prefilled Syringe
☐ Citrate Free(CF) ☐ Original Formula
Hidradenitis Suppurativa Starter:
☐ 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
☐ ***Psoriasis Starter:***
80 mg SubQ day 1, 40 mg SubQ day 8, 40 mg SubQ day 22
Qty: 1 Pack **Refills:** 0
☐***Hidradenitis Suppurativa Maintenance:***
☐ 40 mg SubQ once weekly, beginning day 29
☐ 80 mg SubQ every other week, beginning day 29
☐ ***Psoriasis Maintenance:***
40 mg SubQ every other 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:** 2
☐**Maintenance:** Give dose as an IV infusion every __ weeks
Qty: **Refills:** 2

ILUMYA™ *(tildrakizumab-asmn)* Prefilled Syringe
☐ **Induction:** Inject 100 mg/ml SubQ at weeks 0 and 4
Qty: 2 **Refills:** None
☐**Maintenance:** Inject 100 mg/ml SubQ every 12 weeks
Qty: **Refills:**

LITFULO™ *(ritlecitinib)* capsule
☐ 50 mg by mouth once daily
Qty: 28 **Refills:**

ODOMZO® *(sonidegib)* capsule 200 mg on an empty stomach, at least 1 hr before or 2 hrs after a meal
Qty: 30 **Refills:**

OLUMIANT® *(baricitinib)* tablets
☐ 2 mg PO once daily ☐ 4 mg PO once daily
Qty: **Refills:**

OTEZLA® (*apremilast*)
☐ **Titration Pack:**
PO as directed per package instructions
Qty: 1 Pack **Refills:** 0
☐ **Bridge Pack:**
PO as directed per package instructions
Qty: 1 Pack **Refills:**
☐ **Maintenance:** (30 mg) PO twice daily
Qty: 30 days **Refills:**

REMICADE® (*infliximab*) 100 mg vials ☐ Biosimilar authorized
☐ **Induction:** 5 mg/ kg as an IV infusion at 0, 2, and 6 weeks
Qty: 1 dose Refills: 2
☐**Maintenance:** 5 mg/ kg as an IV infusion every 8 weeks
Qty: **Refills:**

RINVOQ® (*upadacitinib*) extended-release tablets
☐ 15 mg ☐ 30 mg
Once daily PO with or without food
Qty: **Refills:**

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

SILIQ® (*brodalumab*) Prefilled Syringe
☐ **Induction:** Inject 210 mg SubQ weeks 0 and 1
Qty: 2 **Refills:** 0
☐ **Maintenance:** Starting at Week 2 of therapy, inject 210 mg SubQ every 2 weeks
Qty: 2 **Refills:**

SKYRIZI™ *(risankizumab-rzaa)*
☐ Prefilled Syringe ☐ Pen
☐ Inject 150 mg (1 injection) SubQ at Week 0, Week 4
Qty: 2 syringes **Refills:**
☐ **Maintenance:** Inject 150 mg SubQ every 12 weeks
Qty: **Refills:**

STELARA® (*ustekinumab*)
☐ 45 mg Prefilled Syringe ☐ 90 mg Prefilled Syringe
☐ **Induction:**
Inject contents of 1 syringe SubQ on day 0 and day 28
Qty: 1 syringe **Refills**: 1
☐ **Maintenance:**
Inject contents of 1 syringe SubQ every 12 weeks
Qty: 1 syringe **Refills:**

SOTYKTU™ *(deucravacitinib)* 6 mg tablet
Once daily PO with or without food
Qty: **Refills:**

TALTZ® (*ixekizumab*)
☐ Citrate Free(CF)
☐ AutoInjector ☐ Prefilled Syringe
☐ ***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
☐ ***Psoriatic Arthritis Induction:*** Inject 160 mg (2 x 80 mg) 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:**

☐ **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:

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