BioPlus® Specialty Pharmacy
A Carelon Company

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

NEUROLOGY & MULTIPLE SCLEROSIS REFERRAL FORM

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

PATIENT INFORMATION

Patient Name:	SSN:		DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell:	Email:	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 #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

PRIOR TREATMENT HISTORY ☐ **AVONEX®** ☐ **BETASERON®** ☐ **COPAXONE®** ☐ **GILENYA®** ☐ **Rebif®** ☐ **Other**_____

MS MEDICATIONS

AVONEX® (interferon beta-1a)* ☐ Enroll in Above MS™ 30 mcg (☐ Prefilled Syringe ☐ Pen) Inject IM once weekly
Qty: 4 **Refills:**

BETASERON® (interferon beta-1b)* ☐ Enroll in BETAPLUS®
☐ **Starting Titration:** 62.5 mcg SubQ every other day for weeks 1 and 2, 125 mcg SubQ every other day for weeks 3 and 4, 187.5 mcg SubQ every other day for weeks 5 and 6, 250 mcg SubQ every other week for weeks 7 and 8
Qty: 30 days **Refills:** 1
☐ **Maintenance Dosing:** 250 mcg (1 ml) SubQq every other day ☐ BetaConnect
Qty: 14 **Refills:**

COPAXONE® (glatiramer acetate) ☐ Enroll in Shared Solutions® ☐ Enroll in Mylan ADVOCATE®
☐ 20 mg SubQ every day ☐ 40 mg SubQ three times per week
Qty: 28 days **Refills:**

Dalfampradine ☐ 10 mg by mouth every 12 hours
Qty: 60 **Refills:**

EXTAVIA® (interferon beta-1b) ☐ Extavia Go Program®
☐ **Starting Titration:** 62.5 mcg SubQ every other day for weeks 1 and 2, 125 mcg SubQ every other day for weeks 3 and 4, 187.5 mcg SubQ every other day for weeks 5 and 6, 250 mcg SubQ every other week for weeks 7 and 8
Qty: 30 days **Refills:** 1
☐ **Maintenance Dosing:** 250 mcg (1 ml) SubQ every other day
Qty: 15 **Refills:**

FINGOLIMOD® (gilenya) ☐ 0.5 mg PO once a day ☐ 0.25 mg PO once a day
Qty: 30 **Refills:**

GILENYA® (fingolimod) ☐ Enroll in Gilenya Go Program® ☐ 0.5 mg PO once a day
Qty: 30 **Refills:**

KESIMPTA®(ofatumumab) ☐ Sensoready® Pen
☐ **Starting Dose:** 20 mg SubQ administered at week 0, 1, and 2
☐ **Maintenance Dosing:** 20 mg administered monthly starting at week 4
Qty: **Refills:**

MAVENCLAD® (cladribine) 10 mg tablet ☐ Take daily by mouth at intervals of 24 hours

Weight Range (kg)	Number of 10 mg tablets per week												
	Week 1						Week 5						
	Day 1	Day 2	Day 3	Day 4	Day 5	Total Tablets Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Total Tablets Week 5	Total Tablets
☐ 40 to < 50	1	1	1	1	0	4	1	1	1	1	0	4	8 (80mg)
☐ 50 to < 60	1	1	1	1	1	5	1	1	1	1	1	5	10 (100 mg)
☐ 60 to < 70	2	1	1	1	1	6	2	1	1	1	1	6	12 (120 mg)
☐ 70 to < 80	2	2	1	1	1	7	2	2	1	1	1	7	14 (140 mg)
☐ 80 to < 90	2	2	2	1	1	8	2	2	2	1	1	7	15 (150 mg)
☐ 90 to < 100	2	2	2	2	1	9	2	2	2	2	1	8	17 (170 mg)
☐ 100 < 110	2	2	2	2	2	10	2	2	2	2	2	9	19 (190 mg)
☐ 110 and above	2	2	2	2	2	10	2	2	2	2	2	10	20 (200 mg)

# of tablets: **# of cycles:**

MAYZENT® (siponimod) ☐ Please complete Mayzent Prescription Start Form and attach to this referral form.

PLEGRIDY® (peginterferon beta-1a)
Induction: ☐ Prefilled Syringe ☐ Pen
63 mcg SubQ on day 1, 94 mcg SubQ on day 15
Qty: 1 pack **Refills:** None
Maintenance: 125 mcg/0.5 ml ☐ Prefilled Syringe ☐ Pen
125 mcg SubQ every 14 days, starting day 29 of therapy
Qty: 2 **Refills:**

PONVORY® (ponesimod) tablets
☐ **Starting Titration:** 2 mg PO day 1 and 2, 3 mg PO day 3 and 4, 4 mg PO day 5 and 6, 5 mg PO day 7, 6 mg PO day 8, 7 mg PO day 9, 8 mg PO day 10, 9 mg PO day 11, 10 mg PO day 12,13 and 14.
Qty: 1 pack **Refills:** None
☐ **Maintenance:** 20 mg PO once daily
Qty: 30 **Refills:**

OCREVUS™ (ocrelizumab)
☐ **Starting Dose:** 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion
☐ **Maintenance:** 600 mg intravenous infusion every 6 months
Qty: **Refills:**

OZOBAX™ (baclofen) 5 mg/ml Oral Solution ☐ Goal Dose: ___ mg/day (should be divided into 3-4 doses)
Directions: Increase dose slowly every 3 days by 5 mg PO 3 times/day up to goal dose

Rebif® (interferon beta-1a) ☐ Enroll in MS LifeLines® ☐ Prefilled Syringe/Rebiject II®* ☐ Rebif Rebidose®
Titration Pack:
☐ Goal Dose 22 mcg: (Full dose therapy beginning week 5) 4.4 mcg/0.1 ml SubQ three times weekly week 1-2, 11 mcg/0.25 mLSubQ three times weekly weeks 3-4
☐ Goal Dose 44 mcg: (Full dose therapy beginning week 5) 8.8 mcg/0.1 ml SubQ three times weekly week 1-2, 22 mcg/0.25 ml three times weekly weeks 3-4
Qty: 1 pack **Refills:** None
Maintenance Dosing: ☐ 44 mcg ☐ 22 mcg SubQ three times per week
Qty: **Refills:**
***Rebiject** (Will come from MS Lifelines®)

TECFIDERA® (dimethyl fumarate) ☐ 120 mg (14 per bottle 7 day supply) ☐ 240 mg (60 per bottle 30 day supply)
☐ **Starting Dose:** 120 mg twice a day, PO, day 1 through 7
☐ **Maintenance Dosing:** Starting day 8, 240 mg PO twice daily
Qty: **Refills:**

Teriflunomide (generic for **Aubagio®**) ☐ 7 mg PO once daily, with or without food.
Qty: 30 **Refills:**

VUMERITY™ (diroximel fumarate)
☐ **Starting Dose:** Take 1 capsule (231 mg) orally twice daily for 7 days, then increase to 2 capsules (462 mg) twice daily.
Qty: 106 **Refills:** None
☐ **Maintenance Dosing:** Take 2 capsules (462 mg) PO twice a day
Qty: 120 **Refills:**
☐ **Alternate Maintenance Dosing:** Take _____ capsules (_____ mg) PO twice a day
Qty: 120 **Refills:**

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

☐ **OTHER**
STRENGTH:

SIG/DIRECTIONS:

REFILLS: **QUANTITY:**

*AVAILABLE IN GENERIC

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 #	
Prescriber 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, including appeals and peer to peer reviews, for the prescribed medications We will also pursue available copay and financial assistance on behalf of your patients.

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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
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