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
☐ Inject 300 mg SubQ every week
Qty: 4 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.****

OMVOH™ *(mirikizumab-mrkz)*
☐ Vial 20 mg/mL ☐ Prefilled Syringe 100 mg/mL
☐ **IV Induction:** Inject 300 mg IV at weeks 0, 4, 8
Qty: 1 **Refills:** 2
☐ **Maintenance:** ☐ 2 x 100 mg SubQ weeks 12 and every 4 weeks
Qty: 2 Prefilled Syringes **Refills:** ____

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: ____ **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**: ____

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	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:

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
Santa Barbara Specialty Pharmacy 4690 Carpinteria Ave, Ste B, Carpinteria, CA 93013

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