BioPlus Specialty Pharmacy
A Carelon Company

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RHEUMATOLOGY

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

PATIENT INFORMATION

Name:		SSN:	DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell:	Email:	Gender: Female Male

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® ☐ Cimzia® ☐ Cosentyx® ☐ Enbrel® ☐ Humira® ☐ Kevzara® ☐ Orencia® ☐ Otezla® ☐ Other: ________________

Prior Methotrexate/Oral Systemic Medications: ☐ Yes ☐ No ☐ Contraindicated

INSURANCE INFORMATON (or attach copy of the cards)

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

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

ACTEMRA® *(tocilizumab)*
Maintenance: ☐ 80 mg/4 mL ☐ 200 mg/10 mL
☐ 400 mg/20 mL ☐ 162 mg/0.9 mL PFS
☐ 162 mg/0.9 mL pen
☐ **Infuse** (☐ 4 mg/kg ☐ 8 mg/kg) IV every 4 weeks
☐ **Inject** 162 mg SUBQ (☐ QOW ☐ QW)
Qty: ____ **Refills:** ____

AMJEVITA™ *(adalimumab-atto)* ☐ SureClick 40 mg/0.8 mL
☐ PFS 20 mg/0.4 mL ☐ PFS 40 mg/0.8 mL
☐ **Inject** 40 mg every other week and ____ mg every other week
Qty: ____ **Refills:** ____

CIMZIA® *(certolizumab pegol)* PFS
Induction: ☐ Inject 100 mg SUBQ at weeks 2 and 4
☐ Inject 400 mg (2 x 200 mg) SUBQ at weeks 0, 2, and 4
Qty: 6 **Refills:** ____
Maintenance: ☐ 50 mg SUBQ every other week
☐ 100 mg SUBQ every other week
☐ 200 mg SUBQ every 2 weeks
☐ 400 mg (2 x 200 mg) SUBQ every 4 weeks
☐ 400 mg (2 x 200 mg) SUBQ every 2 weeks
Qty: ____ **Refills:** ____

COSENTYX™ *(secukinumab)*
75 mg ☐ 75 mg PFS
☐ **Induction:** Inject 75 mg SUBQ at weeks 0, 1, 2, 3
Qty: 28 days **Refills:** 0
☐ **Maintenance:** Inject 75 mg SUBQ on week 4, then every 4 weeks
Qty: 28 days **Refills:** ____
150 mg ☐ 150 mg Sensoready® Pen Kit ☐ 150 mg PFS
☐ **Induction:** Inject 150 mg SUBQ at weeks 0, 1, 2, 3
Qty: 5 **Refills:** ____
☐ **Maintenance:** Inject 150 mg SUBQ on week 4, then every 4 weeks
Qty: 28 days **Refills:** ____
300 mg ☐ UnoReady Pen (1 x 300 mg/2mL)
☐ Sensoready® Pen Kit (2 x 150 mL) ☐ PFS (2 x 150 mL)
☐ **Induction:** Inject 300 mg SUBQ at weeks 0, 1, 2, 3
Qty: 28 days **Refills:** 0
☐ **Maintenance:** Inject 300 mg SUBQ on week 4, then every 4 weeks
Qty: 28 days **Refills:** ____
☐ Bridge*

ENBREL® *(etanercept)*
☐ Mini cartridge ☐ PFS
☐ AutoInjector ☐ Vial
☐ 25 mg ☐ 50 mg
☐ Once weekly SUBQ ☐ Twice weekly SUBQ
Qty: ☐ 4 ☐ 8 **Refills:** ____

HUMIRA® *(adalimumab)*
☐ Pen ☐ PFS
☐ Citrate free (CF) ☐ Original formula
☐ 40 mg SUBQ every other week
☐ 40 mg SUBQ once a 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:** ____
☐ **Maintenance:** Give dose as an IV infusion every __ weeks
Qty: ____ **Refills:** ____

KEVZARA® *(sarilumab)* ☐ Pen ☐ PFS
☐ 150 mg ☐ 200 mg
Dosing: Inject SUBQ every 2 weeks.
Qty: 2 **Refills:** ____

OLUMIANT® *(baricitinib)* ☐ 1 mg tablet ☐ 2 mg tablet
☐ Take 1 tablet PO daily
Qty: ____ **Refills:** ____

ORENCIA® *(abatacept)* ☐ 125 mg PFS
☐ 250 mg vial ☐ 125 mg autoinjector
☐ Inject 125 mg SUBQ once a week.
☐ Infuse ___mg IV at Weeks 0, 2, and 4 then every 4 weeks
Qty: 4 week supply **Refills:** ____

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

REMICADE® *(infliximab)* 100 mg vials ☐ Biosimilar authorized
☐ 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:** ____

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

SIMLANDI® *(adalimumab-ryvk)* 40 mg
☐ PFS
☐ Inject SUBQ 40 mg every other week
Qty: 1 **Refills:** ____

SIMPONI® *(golimumab)* 50 mg
☐ PFS ☐ Autoinjector
Inject SUBQ once a month
Qty: 1 **Refills:** ____

SKYRIZI™ (risankizumab-rzaa)
☐ PFS ☐ Pen
☐ Inject 150 mg (1 injection) SUBQ at Week 0, Week 4, and then every 12 weeks
Qty: 1 **Refills:** ____

STELARA® *(ustekinumab)*
☐ 45 mg PFS ☐ 90 mg PFS
Inject contents of 1 syringe SUBQ on day 0, then week 4, then every 12 weeks
Qty: 1 **Refills:** ____

TALTZ® *(ixekizumab)* ☐ Autoinjector ☐ PFS
☐ Citrate free (CF)
☐ **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:** ____
☐ **Psoriatic Arthritis Induction**: Inject 160 mg (2 x 80 mg injections) SUBQ at week 0
Qty: 2 **Refills:** 0
☐ **Maintenance:** 80 mg SUBQ every 4 weeks
Qty: 1 **Refills:** ____

TREMFYA® *(guselkumab)*
☐ PFS ☐ 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:** ____

XELJANZ® *(tofacitinib)*
☐ 5 mg tablet ☐ 11 mg XR tabs
☐ Take one 5 mg tablet PO twice daily
☐ Take one 11 mg tablet PO once daily
Qty: ____ **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:	City:	State:
NPI #:	Tax ID#:	Ship To: ☐ Patient ☐ MD Office
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.