

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Address		Address	
City State ZIP		City State ZIP	
Main Phone	Alternate Phone	Phone	Fax
Social Security #		Contact Person	
Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	DEA #	NPI # License #

Clinical Information	
Diagnosis: <input type="checkbox"/> K50.90 Pediatric Crohn's Disease <input type="checkbox"/> K51.90 Pediatric Ulcerative Colitis <input type="checkbox"/> K20.0 Eosinophilic Esophagitis <input type="checkbox"/> Other: _____ Dx Code: _____	
Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____ _____ Length of Treatment: _____ Reason for Discontinuing: _____ _____ Length of Treatment: _____ Reason for Discontinuing: _____	
Drug Allergies	Latex Allergy: <input type="checkbox"/> No <input type="checkbox"/> Yes
Weight <input type="checkbox"/> kg <input type="checkbox"/> lbs TB Test: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (please send lab results)	Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing

Prescription Information			Qty	Refills
<input type="checkbox"/> Dupixent® *12+ years old, ≥40 kg	300 mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS w/Shield	<input type="checkbox"/> Inject 300 mg SUBQ every week	4 Injections	_____
<input type="checkbox"/> Humira® Citrate Free Crohn's	17 kg to <40 kg 20 mg PFS	<input type="checkbox"/> Load: Inject 80 mg SUBQ on Day 1, then inject 40 mg on Day 15, then inject 20 mg every other week starting on Day 29 <input type="checkbox"/> Maintenance: Inject 20 mg SUBQ every other week	Loading Dose (6 PFS)	None
	≥40 kg <input type="checkbox"/> Crohn's/UC Starter Package (3-80 mg pens) <input type="checkbox"/> 40 mg Pen	<input type="checkbox"/> Load: Inject 160 mg SUBQ as <input type="checkbox"/> two-80 mg injections on Day 1 or <input type="checkbox"/> 80 mg on Day 1 and then Day 2, then inject 80 mg on Day 15, then inject 40 mg every other week starting on Day 29 <input type="checkbox"/> Maintenance: Inject 40 mg SUBQ every other week	4 Week Supply	_____
<input type="checkbox"/> Humira® Citrate Free UC	20 kg to <40 kg 40mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS 20 mg <input type="checkbox"/> PFS 40 mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Load: Inject 80 mg SUBQ on Day 1, then inject 40 mg on Day 8 and Day 15, then inject maintenance dose starting on Day 29 <input type="checkbox"/> Maintenance: Inject 20 mg SUBQ every week <input type="checkbox"/> Maintenance: Inject 40 mg SUBQ every other week	Loading Dose (4 pens/PFS)	None
	≥40 kg <input type="checkbox"/> Pediatric UC Disease Starter Package (4 count) 80 mg/0.8 mL in a single-use pen <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 80 mg Pen	<input type="checkbox"/> Load: Inject 160 mg SUBQ as <input type="checkbox"/> two-80 mg injections on Day 1 or <input type="checkbox"/> 80 mg on Day 1 and then Day 2, then inject 80 mg on Day 8 and Day 15, then inject maintenance dose starting on Day 29 <input type="checkbox"/> Maintenance: Inject 40 mg SUBQ every week <input type="checkbox"/> Maintenance: Inject 80 mg SUBQ every other week	4 Week Supply 4 Week Supply	_____
<input type="checkbox"/> Remicade®	100 mg Vial	<input type="checkbox"/> Load: Infuse _____ mg (5 mg/kg) at 0, 2, and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> Maintenance: Infuse _____ mg (5 mg/kg) every 8 weeks	Loading Dose	None
<input type="checkbox"/> Other			8 Week Supply	_____

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) Substitution Permitted

Date

Prescriber's Signature (no stamps) Dispense As Written

Date

BSP250626