

Pediatric Dermatology A-G

A Carelon Company

Fax: 800-269-5493

Phone: 888-292-0744

bioplusrx.com/therapy

Need By D	ate: Ship	o To: Patient Office Other	Fax Copy: □ R	x Card Front/Back	☐ Clinical No	tes 🗆 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		□ Female □ Male	DEA#	NPI#		License #		
			formation					
		derate to Severe Plaque Psoriasis L40.50 Psor						
	☐ Hands ☐ Feet ☐ Knees ☐ ☐ Hands ☐ Feet ☐ Scalp ☐	□ Spine □ Groin □ Nails □ Other:			% BS/	A:		
Prior Failed Meds:	☐ Biologics:							
Drug Allergies	☐ Topical:		Dther:					
						Latex Allergy: ☐ No ☐ Yes		
Weight	☐ kg ☐ lbs ☐ TB Test: ☐ No ☐ Yes ☐ Status: ☐ Negative ☐ Positive (please send lab results) ☐ New						uing	
		Prescription	Information			Qty	Refills	
□ Adbry®	150 mg PFS	☐ Load: Inject 300 mg (as two-150 mg inject SUBQ every other week starting on Day		ect 150 mg	2	2 Syringes	None	
*12+ Years Old			☐ Maintenance: Inject 150 mg SUBQ every other week starting on Day 15					
☐ Cibinqo™ *12+ Years Old	☐ 50 mg ☐ 100 mg ☐ 200 mg	☐ Take 1 tablet by mouth once daily			3	30 Tablets		
□ Cosentyx®	☐ 75 mg PFS	☐ Load: Inject 75 mg SUBQ on week 0, 1,				Week Supply Week Supply	None	
	150 mg □ Pen □ PFS	 □ Maintenance: Inject 75 mg SUBQ on we □ Load: Inject 150 mg SUBQ on week 0, 1 □ Maintenance: Inject 150 mg SUBQ on w 	, 2, 3 (≥50 kg)	, ,,	4	Week Supply Week Supply Week Supply	None	
☐ Dupixent® *Age 6 Months-	☐ 200 mg PFS w/Shield ☐ 200 mg Pen (2+ years old)	☐ Inject 200 mg SUBQ every 4 weeks (5 kg		(1.5)	2	2 Syringes		
5 Years Old	□ 300 mg PFS w/Shield □ 300 mg Pen (2+ years old)	☐ Inject 300 mg SUBQ every 4 weeks (15	kg to <30 kg)		2	2 Syringes		
☐ Dupixent®	□ 300 mg PFS w/Shield □ 300 mg Pen	☐ Load: Inject 600 mg (as two-300 mg inje 4 weeks starting on Day 29 (15kg to <30kg	ctions in different sites) on Day 1	, then 300 mg every	2	2 Syringes	None	
*Age 6-17 Years Old	□ 300 mg Fen	☐ Maintenance: Inject 300 mg SUBQ once e	every 4 weeks starting on Day 29	(15 kg to <30 kg)		2 Syringes		
	□ 200 mg PFS w/Shield□ 200 mg Pen	□ Load: Inject 400 mg (as two-200 mg inject other week starting on Day 15 (30 kg to <	:60 kg)	,		2 Syringes 2 Syringes	None	
	☐ 300 mg PFS w/Shield	☐ Maintenance: Inject 200 mg SUBQ once ev☐ Load: Inject 600 mg (as two-300 mg inje				2 Syringes	None	
	☐ 300 mg Pen	other week starting on Day 15 (≥60 kg) ☐ Maintenance: Inject 300 mg SUBQ every	, ,			2 Syringes		
□ Ebglyss™ *12+ Years Old: ≥40 kg	☐ 250 mg Pen ☐ 250 mg PFS	☐ Initial: Inject 500 mg (as two-250 mg inje ☐ Induction: Inject 250 mg SUBQ every 2 v If additional induction dosing is needed, c	veeks (weeks 4-14).	ek 2	2	Injections Injections	None 2	
		☐ Maintenance: Inject 250 mg SUBQ every				I Injection		
□ Enbrel®	50 mg □ SureClick® □ PFS □ Mini	☐ Inject 50 mg SUBQ once a week (≥63 kg☐ Inject 25 mg SUBQ once a week	3)			Week Supply Week Supply		
	□ 25 mg PFS□ 25 mg/0.5 mL SDV	☐ Inject 25 mg 30bQ once a week ☐ Inject mg (0.8 mg/kg) subcut	caneously once a week (<63 kg)			Week Supply		
□ Other								
D. C. C. W. C.	1 · · · · · · · · · · · · · · · · · · ·				4.5	en		

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.

Date



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□ Other: Har Skin: □ Har Skin: □ Har Skin: □ Har Prior Failed Meds: □ Bio □ Top Drug Allergies Weight □ Humira® HS □ PsO (Pens Adol: 260 kg 40 mg 40 mg Humira® HS □ Citrate Free Adol: 260 kg 40 mg □ Humira® HS □ HS 3	oic Dermatitis	ernate Phone Female	Prescriber Name Address City State ZIP Phone Contact Person DEA# Iformation riatic Arthritis		Fax rley Stage: Dx Code: % BS/	License #				
Address City State ZIP Main Phone Social Security # Date of Birth Diagnosis: L20.9 Atopic Dother: L20.9 Atopic L2	oic Dermatitis	Female	Address City State ZIP Phone Contact Person DEA# Iformation riatic Arthritis	nitis Suppurativa - Hu	rley Stage: Dx Code: % BS/		-			
City State ZIP Main Phone Social Security # Date of Birth Diagnosis: □ L20.9 Atopic □ Other: □ □ Location: Joints: □ Har Skin: □ Har Prior Failed Meds: □ Bio □ Top Drug Allergies Weight □ Humira® HS Citrate Free Adol: 30 kg-59 kg □ Humira® HS Citrate Free Adol: 260 kg □ Homira® HS Citrate Free HS Adol: ≥6 0kg □ HS □ HS Citrate Free HS Adol: ≥6 0kg □ R0 m	oic Dermatitis	Female	City State ZIP Phone Contact Person DEA# Iformation riatic Arthritis	nitis Suppurativa - Hu	rley Stage: Dx Code: % BS/					
Main Phone Social Security # Date of Birth Diagnosis: □ L20.9 Atopic □ Other: □ Location: Joints: □ Har Skin: □ Har Prior Failed Meds: □ Bio □ Top Drug Allergies Weight □ Humira® HS Citrate Free Adol: 30 kg-59 kg □ Humira® HS Citrate Free Adol: 260 kg □ Humira® HS Citrate Free HS Adol: ≥60 kg □ Humira® HS Citrate Free HS Adol: ≥60 kg □ Homira® HS Citrate Free HS Adol: ≥60 kg □ Homira® HS Citrate Free HS Adol: ≥60 kg □ R0 m	oic Dermatitis	Female	Phone Contact Person DEA# of ormation riatic Arthritis	nitis Suppurativa - Hu	rley Stage: Dx Code: % BS/					
Oate of Birth Diagnosis: □ L20.9 Atopic □ Other: □ Docation: Joints: □ Har Skin: □ Har Skin: □ Har Prior Failed Meds: □ Bio □ Top Drug Allergies Weight □ Humira® HS Citrate Free Adol: 30 kg-59 kg 40 mg □ Humira® HS Citrate Free Adol: ≥60 kg 40 mg □ Humira® HS Citrate Free HS Adol: ≥60 kg □ R0 mg	oic Dermatitis	Female	Contact Person DEA# Information riatic Arthritis	nitis Suppurativa - Hu	rley Stage: Dx Code: % BS/					
late of Birth lagnosis:□ L20.9 Atopic □ Other: ocation: Joints: □ Har Skin: □ Har rior Failed Meds: □ Bio □ Top large Allergies Humira® HS Citrate Free Pso (Pens Pso (Pens Pso (Pens Pso (Pso (Pso (Pso (Pso (Pso (Pso (Pso	ands	Clinical In ate to Severe Plaque Psoriasis	DEA# DEA# Information riatic Arthritis	nitis Suppurativa - Hu	Dx Code: % BSA		-			
iagnosis:□ L20.9 Atopic □ Other: □ cocation: Joints: □ Har Skin: □ Har rior Failed Meds: □ Bio □ Top rug Allergies /eight Humira® HS Citrate Free dol: 30 kg-59 kg Humira® HS Citrate Free dol: ≥60 kg Humira® HS Citrate Free HS Citrate Free Gens dol: ≥60 kg Humira® HS Citrate Free HS	ands	Clinical In ate to Severe Plaque Psoriasis	nformation riatic Arthritis	nitis Suppurativa - Hu	Dx Code: % BSA		-			
□ Other: Docation: Joints: □ Harrion Failed Meds: □ Bio □ Toprug Allergies Humira® HS □ PsO (Pens dol: ≥60 kg 40 mg Humira® HS □ HS (Pens S Adol: ≥6 0kg 80 ng 80 ng 80 ng 10 mg	ands	Clinical In ate to Severe Plaque Psoriasis	riatic Arthritis		Dx Code: % BSA		_			
□ Other: Docation: Joints: □ Har Skin: □ Har Fior Failed Meds: □ Bio □ Top Failed Meds: □ Failed M	ands	ate to Severe Plaque Psoriasis	riatic Arthritis		Dx Code: % BSA		_			
□ Other: □ Har Skin: □ Har Skin: □ Har Skin: □ Har Idea Meds: □ Bio □ Top Idea Meds: □ Bio □ Top Idea Meds: □ Bio □ Top Idea Meds: □ Har Idea	ands	Spine Groin □ Nails □ Other:	□ Oral:		Dx Code: % BSA		-			
Skin: □ Har ior Failed Meds: □ Bio □ Top rug Allergies eight Humira® HS Citrate Free tol: 30 kg-59 kg Humira® HS Citrate Free tol: ≥60 kg Humira® HS Citrate Free S Adol: ≥6 0kg □ B0 n	ands	Groin 🗆 Nails 🗆 Other:	☐ Oral:							
rior Failed Meds: ☐ Bio ☐ Top rug Allergies deight Humira® HS Citrate Free dol: 30 kg-59 kg Humira® HS Citrate Free dol: ≥60 kg Humira® HS Citrate Free S Adol: ≥6 0kg ■ 80 n	iologics:		☐ Oral:			A:				
Humira® HS Citrate Free dol: ≥60 kg										
Humira® HS Citrate Free dol: 30 kg-59 kg Humira® HS Citrate Free dol: ≥60 kg Humira® HS Citrate Free S Adol: ≥6 0kg □ S0 □ S0 □ S0	□ kg □ lbs TB	Test: □ No □ Yes		☐ Other: Latex Allergy: ☐ No ☐ Yes						
Citrate Free dol: 30 kg-59 kg 40 mg Humira® HS Citrate Free dol: ≥60 kg 40 mg Humira® HS Citrate Free S Adol: ≥6 0kg 980 m		//eight □ kg □ lbs TB Test: □ No □ Yes Date: Results: □ Negative □ Positive (please send lab r					Status:			
Citrate Free (Pensido: 30 kg-59 kg 40 mg Humira® HS Citrate Free (Pensido: ≥60 kg 40 mg Humira® HS Citrate Free (Pensido: ≥60 kg 40 mg Humira® HS Citrate Free S Adol: ≥6 0kg		Prescription	Information			Qty	Refills			
Humira® HS HS 3 (Pens dol: ≥60 kg	O/UV Starter Pkg	☐ Load: Inject 80 mg SUBQ on Day 1, then week thereafter		ery other	Lo	pading Dose	None			
Citrate Free (Pens dol: ≥60 kg 40 mg Humira® HS Citrate Free (Pens S Adol: ≥6 0kg 80 n	g □ Pen □ PFS	☐ Maintenance: Inject 40 mg SUBQ every c	other week			Week Supply				
40 mg Humira® HS Citrate Free (Pens S Adol: ≥6 0kg □ 80 n	S Starter Pkg ns only)	□ Load: Inject 160 mg SUBQ as □ two-80 injection on Day 1 and then Day 2, then in thereafter starting on Day 29	mg injections on Day 1 or □ one nject 80 mg on Day 15, then inject	e-80 mg t 40 mg every week		oading Dose	None			
Citrate Free (Pens S Adol: ≥6 0kg	p □ Pen □ PFS	☐ Maintenance: Inject 40 mg SUBQ every v				Week Supply	None			
50	S Starter Pkg ns only)	□ Load: Inject 160 mg SUBQ as □ two-80 mg injections on Day 1 or □ one-80 mg injection on Day 1 and then Day 2, then inject 80 mg on Day 15, then inject 80 mg every other week thereater starting on Day 29 □ Maintenance: Inject 80 mg SUBQ every other week				oading Dose Week Supply	None			
Littulo	g Capsule	☐ Take 1 capsule by mouth once daily	oner week			3 Capsules				
P+ Years Old Nemluvio® 30 mg F P+ Years Old	J Pen	☐ Load: Inject 60 mg (as two-30 mg pens) S				Pens Pen	None			
-	mg-20 mg Starter Pack	☐ Maintenance: Inject 30 mg (1 pen) SUBQ☐ ☐ Take 1 tablet by mouth on Day 1 then twi		ded		Starter Pack	None			
0 kg to <50 kg	mg Tablet	a Support Plus Start Form and fa	x to	60) Tablets					
Otezla® □ 10 n	mg-20 mg-30 mg rter Pack	BioPlus Specialty Pharmacy at 800-269-549 ☐ Take 1 tablet by mouth on Day 1 then twi		ded	1	Starter Pack	None			
o0 kg	mg Tablet	☐ Take 1 tablet by mouth twice daily For Bridge Requests please utilize the Otezl: BioPlus Specialty Pharmacy at 800-269-549	a Support Plus Start Form and fa	x to	60) Tablets				
Other			-							
u siming this form, you are a the		life ampleuses to serve as your designated agent in a street when	clinical and other required information to their	d party payare with roop	to this prescription co-	l any refills or conti	lation of the same			
nd dose for this patient. IMPORT	horizing RioDlue Specialty Dharman	t its employees to serve as your designated agent in submitting of be delivered only to the named addressee. It contains material lately if you have received this document in error and then desti-	Il that is confidential, privileged property, or							



Pediatric Dermatology P-Z

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Ship To: ☐ Patient ☐ Office ☐ Other _ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back Need By Date: _ **Patient Information Prescriber Information** Patient Name Prescriber Name Address Address City State ZIP City State ZIP Main Phone Alternate Phone Social Security # Contact Person Date of Birth NPI# License # ☐ Female ☐ Male **Clinical Information** Diagnosis: 🗆 L20.9 Atopic Dermatitis 🖂 L40.0 Moderate to Severe Plaque Psoriasis 🖂 L40.50 Psoriatic Arthritis 🖂 L73.2 Hidradenitis Suppurativa - Hurley Stage: ☐ Other: Dx Code: Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine Skin:

Hands

Feet

Scalp

Groin

Nails

Other: % BSA: ☐ Oral: Prior Failed Meds: ☐ Biologics: ☐ Topical: _ ☐ Other: **Drug Allergies** Latex Allergy: ☐ No ☐ Yes Weight □ kg □ lbs TB Test: ☐ No ☐ Yes □ New □ Restart □ Continuing Results: ☐ Negative ☐ Positive (please send lab results) Date: Prescription Information Refills Otv ☐ 15 mg ER Tablet ☐ Take 1 tablet by mouth once daily 30 Tablets ☐ Rinvoq® ☐ 30 mg ER Tablet *12+ Years Old: ≥40 kg 1 Vial None ☐ Stelara® ☐ 45 mg Vial (<60 kg) ☐ Starter: Inject ___ ____ mg (0.75 mg/kg) SUBQ on week 0 1 Vial ☐ Maintenance: Inject _ mg (0.75 mg/kg) SUBQ on week 4, then every 12 1 Syringe None □ 45 mg PFS (60 kg to ≤100 kg) ☐ Starter: Inject 1 syringe SUBQ on week 0 1 Syringe □ 90 mg PFS (>100 kg) ☐ Maintenance: Inject 1 syringe SUBQ on week 4, and then every 12 weeks thereafter 1 Vial None ☐ Stelara® ☐ 45 mg Vial (<60 kg) _ mg (0.75 mg/kg) SUBQ on week 0 1 Vial ☐ Maintenance: Inject ____ weeks thereafter ___ mg (0.75 mg/kg) SUBQ on week 4, then every 12 1 Syringe None □ 45 mg PFS (≥60 kg) $\ \square$ Starter: Inject 1 syringe SUBQ on week 0 1 Syringe ☐ 90 mg PFS (>100 kg with Ps) $\hfill \square$ Maintenance: Inject 1 syringe SUBQ on week 4, and then every 12 weeks thereafter 1 Syringe ☐ Taltz® ☐ 40 mg PFS ☐ Starter: Inject 40 mg SUBQ on Day 1 (<25 kg) None 1 Syringe $\ \square$ 20 mg PFS $\hfill \square$ Maintenance: Inject 20 mg SUBQ every 4 weeks thereafter (<25 kg) 1 Syringe None □ 80 mg PFS ☐ Starter: Inject 80 mg SUBQ on Day 1 (25 kg to 50 kg) 1 Syringe ☐ 40 mg PFS ☐ Maintenance: Inject 40 mg SUBQ every 4 weeks thereafter (25 kg to 50 kg) 2 Syringes None 80 mg □ Pen □ PFS $\ \square$ Starter: Inject 160 mg (as two-80 mg injections) SUBQ on Day 1 (>50 kg) 1 Syringe ☐ Maintenance: Inject 80 mg SUBQ every 4 weeks thereafter (>50 kg) □ Other 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.