

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			
Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Drug Allergies			Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing

Please Attach Supporting Labs and List of OTHER Medications

Med	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/> Aranesp <sup>®</sup>	SDV: <input type="checkbox"/> 25mcg/1mL <input type="checkbox"/> 40mcg/1mL <input type="checkbox"/> 60mcg/1mL <input type="checkbox"/> 100mcg/1mL <input type="checkbox"/> 200mcg/1mL <input type="checkbox"/> 300mcg/1mL PFS: <input type="checkbox"/> 10mcg/0.4mL <input type="checkbox"/> 25mcg/0.42mL <input type="checkbox"/> 40mcg/0.4mL <input type="checkbox"/> 60mcg/0.3mL <input type="checkbox"/> 100mcg/0.5mL <input type="checkbox"/> 150mcg/0.3mL <input type="checkbox"/> 200mcg/0.4mL <input type="checkbox"/> 300mcg/0.6mL <input type="checkbox"/> 500mcg/1mL		_____	_____
<input type="checkbox"/> Doptelet <sup>®</sup>	<input type="checkbox"/> 20mg Tablet Procedure Date (for Chronic Liver Disease-associated thrombocytopenia): _____		_____	_____
<input type="checkbox"/> Elitek <sup>®</sup>	PWVL: <input type="checkbox"/> 1.5mg <input type="checkbox"/> 7.5mg		_____	_____
<input type="checkbox"/> Epogen <sup>®</sup>	SDV: <input type="checkbox"/> 2,000 Units/1mL <input type="checkbox"/> 3,000 Units/1mL <input type="checkbox"/> 4,000 Units/1mL <input type="checkbox"/> 10,000 Units/1mL MDV: <input type="checkbox"/> 20,000 Units/2mL <input type="checkbox"/> 20,000 Units/1mL		_____	_____
<input type="checkbox"/> Exjade <sup>®</sup>	Tablet for Oral Suspension: <input type="checkbox"/> 125mg <input type="checkbox"/> 250mg <input type="checkbox"/> 500mg		_____	_____
<input type="checkbox"/> Fulphila <sup>®</sup>	PFS: 6mg/0.6mL		_____	_____
<input type="checkbox"/> Granix <sup>®</sup>	PFS: <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL SDV: <input type="checkbox"/> 300mcg/1mL <input type="checkbox"/> 480mcg/1.6mL		_____	_____
<input type="checkbox"/> Jadenu <sup>®</sup>	Tablet: <input type="checkbox"/> 90mg <input type="checkbox"/> 180mg <input type="checkbox"/> 360mg Granules: <input type="checkbox"/> 90mg <input type="checkbox"/> 180mg <input type="checkbox"/> 360mg		_____	_____
<input type="checkbox"/> Leukine <sup>®</sup>	<input type="checkbox"/> 250mcg PWVL <input type="checkbox"/> 500mcg/1mL SDV		_____	_____
<input type="checkbox"/> Mozobil	SDV: 24mg/1.2mL		_____	_____
<input type="checkbox"/> 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 payors 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



A Carelon Company

Fax: 800-269-5493

Phone: 888-292-0744

bioplusrx.com

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Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Drug Allergies			Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing

Please Attach Supporting Labs and List of OTHER Medications

Med	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/> Neulasta®	<input type="checkbox"/> 6mg/0.6mL PFS <input type="checkbox"/> Onpro Kit		_____	_____
<input type="checkbox"/> Neupogen®	SDV: <input type="checkbox"/> 300mcg/1mL <input type="checkbox"/> 480mcg/1.6mL		_____	_____
	PFS: <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL		_____	_____
<input type="checkbox"/> Nivestym®	SDV: <input type="checkbox"/> 300mcg/1mL <input type="checkbox"/> 480mcg/1.6mL		_____	_____
	PFS: <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL		_____	_____
<input type="checkbox"/> Nplate®	PWVL: <input type="checkbox"/> 125mcg <input type="checkbox"/> 250mcg <input type="checkbox"/> 500mcg		_____	_____
<input type="checkbox"/> Nyvepria™	PFS: 6mg/0.6mL		_____	_____
<input type="checkbox"/> Procrit®	SDV: <input type="checkbox"/> 2,000 Units/1mL <input type="checkbox"/> 3,000 Units/1mL <input type="checkbox"/> 4,000 Units/1mL		_____	_____
	<input type="checkbox"/> 10,000 Units/1mL <input type="checkbox"/> 40,000 Units/1mL		_____	_____
	MDV: <input type="checkbox"/> 20,000 Units/2mL <input type="checkbox"/> 20,000 Units/1mL		_____	_____
<input type="checkbox"/> Promacta®	Tablet: <input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg		_____	_____
	<input type="checkbox"/> 50mg <input type="checkbox"/> 75mg		_____	_____
	Powder for Oral Suspension: <input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg		_____	_____
<input type="checkbox"/> Retacrit®	SDV: <input type="checkbox"/> 2,000 Units/1mL <input type="checkbox"/> 3,000 Units/1mL <input type="checkbox"/> 4,000 Units/1mL		_____	_____
	<input type="checkbox"/> 10,000 Units/1mL <input type="checkbox"/> 40,000 Units/1mL		_____	_____
<input type="checkbox"/> Udenyca®	PFS: 6mg/0.6mL		_____	_____
<input type="checkbox"/> Zarxio®	PFS: <input type="checkbox"/> 300mcg/0.5mL <input type="checkbox"/> 480mcg/0.8mL		_____	_____
<input type="checkbox"/> Ziextenzo®	PFS: 6mg/0.6mL		_____	_____
<input type="checkbox"/> Other				

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Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date