BioPlus® Specialty Pharmacy
A Carelon Company

Skip this form & e-prescribe! Select BioPlus from your EHR

CROHN'S/UC

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

PATIENT INFORMATION

Name:		SSN:		DOB:
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: ◯ Female ◯ Male
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
□ PFS 20 mg/0.4 mL
□ PFS 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*)
□ PFS
□ 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
Qty: 28 day supply **Refills:** ____

DUPIXENT® (*dupilumab*)
□ PFS □ Pen
□ 200 mg/1.14 mL □ 300 mg/2 mL
□ 15 kg < 30 kg inject 200 mg SUBQ every other week
□ 30 kg < 40 kg inject 300 mg SUBQ every other week
□ 40 kg or more 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 □ PFS
□ 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 □ PFS 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 PFS **Refills:** ____

RINVOQ® *(upadacitinib)* extended-release tablets
□ 45 mg
Induction:
□ 45 mg PO once daily for 8 weeks
□ 45 mg PO once daily for 12 weeks
Qty: 28 **Refills:** ____
Maintenance:
□ 15 mg □ 30 mg
□ 15 mg PO once daily
□ 30 mg PO once daily
Qty: ____ **Refills:** ____

SIMLANDI® (*adalimumab-ryvk)*
□ 40 mg/0.4 mL AutoInjector
□ **Induction:** 160 mg SUBQ on Day 1
Qty: 3 syringes **Refills:** 0
Maintenance:
□ 80 mg on Day 15 and 40 mg every other week starting on Day 29.
Qty: ____ **Refills:** ____

SIMPONI® (*golimumab)*
□ PFS □ Autoinjector
□ **Induction:** 200 mg (2 x 100 mg) SUBQ at week 0
Qty: 2 syringes **Refills:** 0
Maintenance:
□ Starting at week 2 of treatment, 100 mg SUBQ every 4 weeks
Qty: ____ **Refills:** ____

SKYRIZI™ *(risankizumab-rzaa)* □ VIAL
Induction:
□ 600 mg intravenously weeks 0, 4, 8
□ 1,200 mg intravenously weeks 0, 4, 8
Qty: ____ **Refills:** 2
Maintenance: □ OBI
□ 180 mg SUBQ starting at week 12, then every 8 weeks
□ 360 mg SUBQ starting at week 12, then every 8 weeks
Qty:1 **Refills:** ____

SOLESTA® *(dextranomer and sodium hyaluronate)* 1 mL PFS
□ 4 submucosal injections
Qty: 4 **Refills:** ____

STELARA® (*ustekinumab)*
IV Induction: Single dose starting at week 0
□ 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 **Refills:** ____

TREMFYA® (*guselkumab)* □ PFS □ Pen
□ **Induction:** 200 mg IV infused weeks 0, 4, and 8
□ **Induction Pack for Crohn's** 2x200 mg SUBQ at weeks 0, 4, and 8
Qty: ____ **Refills:** ____
Maintenance: □ PFS □ AutoInjecter
□ 100 mg □ 200 mg
□ Inject 100 mg SUBQ at week 16 and every 8 weeks thereafter
□ Inject 200 mg SUBQ at week 12 and every 4 weeks thereafter
Qty: ____ **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 weeks
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 daily; days 5-7: Give 0.46 mg PO daily
Qty: 1 **Refills:** None
□ **Maintenance Dosing:** Starting day 8, 0.92 mg PO 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:** _____ mg/kg every _____ weeks **Refills:** _____

☐ 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:	City:	State:	ZIP:
NPI #:	Tax ID#:	Ship To: ☐ Patient	☐ MD Office
Prescriber Signature:	Date:		