BioPlus® Specialty Pharmacy
A Carelon Company

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# DERMATOLOGY (A-L)

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

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Name: | | | SSN: | DOB: | |
| Address: | | | City: | State: | ZIP: |
| Home Phone: | Cell: | Email: | Height: | Weight: | Gender: ◯ Female ◯ Male |

## INSURANCE INFORMATION (or attach copy of the cards)

| | | | | |
|---|---|---|---|---|
| Primary Insurance: | Policy Holder: | Relationship: | Policy #: | Group #: |
| Secondary Insurance: | Policy Holder: | Relationship: | Policy #: | Group #: |

## CLINICAL INFORMATION

Primary Diagnosis: □ Moderate to Severe Plaque Psoriasis □ Psoriatic Arthritis □ Hidradenitis Suppurativa □ Atopic Dermatitis □ Alopecia Areata □ Pruigo Nodularis □ Other: _____

| | | | | |
|---|---|---|---|---|
| Diagnosis Code (ICD-10):_____ | Date of Diagnosis: | TB Test Completed On: | BSA: | Latex Allergy: ◯ Y ◯ N |

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

**ADBRY™** *(tralokinumab-ldrm)* 150 mg PFS
□ **Induction:** Inject 600 mg (4 x 150 mg) SUBQ
**Qty:** 4 **Refills:** None
**Maintenance:**
□ Inject 300 mg (2 x 150 mg) SUBQ every other week
□ Inject 300 mg (2 x 150 mg) SUBQ every 4 weeks
□ **ADBRY™ Bridge Care™** Program:
Inject 300 mg (2 x 150 mg) SUBQ every other week, starting on Day 15
**Qty:** ☐ **Refills:** ☐

**AMJEVITA™** *(adalimumab-atto)* PFS
□ SureClick 40 mg/0.8 mL □ PFS 20 mg/0.4 mL □ PFS 40 mg/0.8 mL
□ **Induction:** Inject 2 x 40 mg SUBQ
□ **Maintenance**: 40 mg every other week starting 1 week after initial dose
**Qty:** ☐ **Refills:** ☐

**BIMZELX®** *(bimekizumab-bkzx)* 160 mg PFS □ **Bridge**
□ **Induction:** Inject 320 mg (2 x 160 mg) SUBQ at week 0, 4, 8, 12, and 16
**Qty:** 10 syringes **Refills:** ☐
□ **Maintenance:** Inject 320 mg (2 x 160 mg) SUBQ every 8 weeks
**Qty:** 2 syringes **Refills:** ☐
□ **Hidradenitis Suppurativa:** Inject 320 mg (2 x 160 mg) SUBQ at weeks 0, 2, 4, 6, 8, 10, 12, 14, and 16 then every 4 weeks thereafter
**Qty:** 10 syringes **Refills:** ☐

**CIBINQO™** *(abrocitinib)* tablet □ 50 mg □ 100 mg □ 200 mg
□ ___ mg PO once daily
**Qty:** ☐ **Refills:** ☐

**Cimzia®** *(certolizumab pegol)* PFS
□ **Induction:** Inject 2 x 200 mg/mL SUBQ at week 0, 2, and 4
**Qty:** 6 syringes **Refills:** 0
**Maintenance**: □ 2 x 200 mg SUBQ every 4 weeks
□ 2 x 200 mg SUBQ every 2 weeks □ 200 mg SUBQ every 2 weeks
**Qty:** 28 days **Refills:** ☐

**COSENTYX®** *(secukinumab)*
**75 mg** □ PFS
□ **Induction:** Inject 300 mg (2 x 150 mg/mL) SUBQ week 0, 1, 2, 3, 4
**Qty::** 10 **Refills:** 0
□ **Maintenance**: Inject 300 mg SUBQ every 4 weeks
**Qty:** 28 days **Refills:** ☐
**150 mg** □ 150 mg Sensoready® Pen Kit □ 150 mg PFS
□ **Induction:** Inject 150 mg SUBQ week 0, 1, 2, 3, 4
**Qty:** 5 **Refills:** ☐
□ **Maintenance**: Inject 150 mg SUBQ every 4 weeks
**Qty:** 28 days **Refills:** ☐
**300 mg** □ UnoReady Pen (1 x 300 mg/2 mL)
□ Sensoready® Pen Kit (2 x 150 mL) □ PFS (2 x 150 mL)
□ **Induction:** Inject 300 mg SUBQ week 0, 1, 2, 3, 4
**Qty:** 10 **Refills:** 0
□ **Maintenance**: Inject 300 mg SUBQ every 4 weeks
**Qty:** 28 days **Refills:** ☐

**DUPIXENT®** *(dupilumab)* □ PFS □ pen
□ **Induction:** Inject 2 x 300 mg (600 mg) SUBQ Day 1
**Qty:** 2 for 14 days **Refills:** None
□ **Maintenance:** Inject 300 mg SUBQ every other week
**Qty**: 2 for 28 days **Refills:** ☐

**EBGLYSS™** *(lebrikizumab-ibkz)* □ pen
□ **Inital:** Inject 500 mg (2 x 250 mg) SUBQ at week 0 and 2
**Qty:** 4 pens **Refills:** None
□ **Induction:** Inject 250 mg SUBQ every 2 weeks (weeks 4-14)
**Qty:** 2 pens **Refills:** 2
□ **Maintenance:** Inject 250 mg SUBQ every 4 weeks starting week 16
**Qty:** 1 pen **Refills:** ☐

**ENBREL®** *(etanercept)*
□ Mini Cartridge □ PFS □ AutoInjector □ Vial
□ **Induction:** Inject (50 mg) SUBQ twice weekly for three months
**Qty:** 8 **Refills:** 2
**Maintenance:** □ 50 mg □ 25 mg
□ Once weekly SUBQ □ Twice weekly SUBQ
**Qty:** □ 8 □ 4 **Refills:** ☐

**ERIVEDGE™** *(vismodegib)*
□ 150 mg capsule once daily PO, with or without food
**Qty:** 28 days **Refills:** ☐

**HUMIRA®** *(adalimumab)*
□ pen □ PFS □ citrate free (CF) □ original formula
***Hidradenitis Suppurativa Loading:***
□ 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
□ ***Psoriasis Loading:*** 80 mg SUBQ Day 1, 40 mg SUBQ Day 8, 40 mg SUBQ Day 22
**Qty:** □ QS □ Other: ☐ **Refills:** 0
□ ***Hidradenitis Suppurativa Maintenance:***
□ 40 mg SUBQ once weekly, beginning Day 29
□ 80 mg SUBQ every other week, beginning Day 29
□ ***Psoriasis Maintenance:*** 40 mg SUBQ every other week
**Qty:** □ QS for 1 month □ Other: ☐ **Refills:** ☐
*Use 40 mg and/or 80 mg devices as needed to meet insurance and dispensing requirements.

**ICOTYDE™** *(icotrokinra)* tablets
□ 200 mg tablets once daily PO, with or without food
**Qty: 30** **Refills:** ☐

**ILUMYA™** *(tildrakizumab-asmn)* PFS
□ **Induction:** Inject 100 mg/mL SUBQ at weeks 0 and 4
**Qty:** 2 **Refills:** None
□ **Maintenance:** Inject 100 mg/mL SUBQ every 12 weeks
**Qty:** ☐ **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:** 2
□ **Maintenance:** Give dose as an IV infusion every _____ weeks
**Qty:** ☐ **Refills:** 2

**LEQSELVI™** *(deuruxolitnib)* tablets □ 8 mg PO twice daily
**Qty:** ☐ **Refills:** ☐

**LITFULO™** *(ritlecitinib)* capsule □ 50 mg PO once daily
**Qty:** 28 **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

| | | | |
|---|---|---|---|
| Prescriber Name: | Phone: | Fax: | |
| Office Contact: | Email: | | |
| Address: | City: | State: | ZIP: |
| NPI #: | Tax ID#: | Ship To: ☐ Patient | ☐ MD Office |
| Prescriber Signature: | Date: | | |

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# DERMATOLOGY (M-Z)

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## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Name: | | | SSN: | DOB: | |
| Address: | | | City: | State: | ZIP: |
| Home Phone: | Cell: | Email: | Height: | Weight: | Gender: ○ Female ○ Male |

## INSURANCE INFORMATION (or attach copy of the cards)

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## CLINICAL INFORMATION

Primary Diagnosis: ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa ☐ Atopic Dermatitis ☐ Alopecia Areata ☐ Pruigo Nodularis ☐ Other: _____

| | | | | |
|---|---|---|---|---|
| Diagnosis Code (ICD-10):_____ | Date of Diagnosis: | TB Test Completed On: | BSA: | Latex Allergy: ○ Y ○ N |

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

**NEMLUVIO®** *(nemolizumab-ilto)* Auto Injector ☐ 30 mg/mL
☐ ***Prurigo Nodularis* Induction:** Inject 60 mg/mL (2 x 30 mg/mL) SUBQ
**Qty:** 2 **Refills:** None
**Maintenance:** ☐ Patients weighing < 90kg Inject 30 mg/mL SUBQ every 4 weeks
☐ Patients weighing ≥ 90kg Inject 60 mg/mL (2 x 30 mg/mL) SUBQ every 4 weeks
**Qty:** ☐ **Refills:** ☐
☐ ***Atopic Dermatitis* Induction:** Inject 60 mg/mL (2 x 30 mg/mL) SUBQ
**Qty:** 2 **Refills:** None
**Maintenance:** ☐ Inject 30 mg/mL SUBQ every 4 weeks
☐ After week 16 Inject 30 mg/mL SUBQ every 8 weeks
**Qty:** ☐ **Refills:** ☐

**ODOMZO®** *(sonidegib)* capsule
☐ 200 mg on an empty stomach, at least 1 hr before or 2 hrs after a meal
**Qty:** 30 **Refills:** ☐

**OLUMIANT®** *(baricitinib)* tablet
☐ 2 mg PO once daily ☐ 4 mg PO once daily
**Qty:** ☐ **Refills:** ☐

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

**OTEZLA XR™** *(apremilast)* 75 mg tablets
☐ Once daily PO with or without food
**Qty:** ☐ 30 days ☐ 90 days **Refills:** ☐

**REMICADE®** *(infliximab)* 100 mg vial ☐ Biosimilar authorized
☐ **Induction:** 5 mg/kg as an IV infusion at 0, 2, and 6 weeks
**Qty:** 1 dose **Refills:** 2
☐ **Maintenance:** 5 mg/kg as an IV infusion every 8 weeks
**Qty::** ☐ **Refills:** ☐

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

**RHAPSIDO®** *(remibrutinib)* tablets 25 mg
☐ Twice daily PO with or without food
**Qty:** ☐ 60 tablets ☐ 180 tablets **Refills:** ☐

**SILIQ®** *(brodalumab)* PFS
☐ **Induction:** Inject 210 mg SUBQ weeks 0 and 1
**Qty:** 2 **Refills:** 0
☐ **Maintenance:** Starting at Week 2 of therapy, inject 210 mg SUBQ every 2 weeks
**Qty:** 2 **Refills:** ☐

**SIMLANDI®** *(adalimumab-ryvk)* AutoInjector ☐ 40 mg/0.4 mL
☐ **Induction:** Inject 40 mg SUBQ every week.
☐ Inject 40 mg SUBQ every other week. ☐ Inject 80 mg SUBQ every other week.
**Quantity:** 28 days **Refills:** ☐
☐ **Maintenance:** Inject 80 mg SUBQ Day 1, followed by 40 mg every other week starting one week after initial dose
☐ Inject 160 mg SUBQ on Day 1, (given in one day or split over two consecutive days), then 80 mg on Day 15
☐ Begin 40 mg weekly or 80 mg every other week dosing two weeks later starting Day 29
**Quantity:** 84 days **Refills:** ☐

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

**SKYRIZI™** *(risankizumab-rzaa)* ☐ PFS ☐ pen
☐ Inject 150 mg (1 injection) SUBQ at Week 0, Week 4
**Qty:** 2 syringes **Refills:** ☐
☐ **Maintenance:** Inject 150 mg SUBQ every 12 weeks
**Qty:** ☐ **Refills:** ☐

**STELARA®** *(ustekinumab)* ☐ 45 mg PFS ☐ 90 mg PFS
☐ **Induction:** Inject contents of 1 syringe SUBQ on Day 0 and Day 28
**Qty:** 1 syringe **Refills:** 1
☐ **Maintenance:** Inject contents of 1 syringe SUBQ every 12 weeks
**Qty:** 1 syringe **Refills:** ☐

**SOTYKTU™** *(deucravacitinib)* 6 mg tablet
☐ Once daily PO with or without food
**Qty:** ☐ **Refills:** ☐

**TALTZ®** *(ixekizumab)* ☐ citrate free (CF) ☐ AutoInjector ☐ PFS
☐ ***Psoriasis Induction:*** Inject 160 mg (2 x 80 mg) SUBQ at week 0; Inject 80 mg at weeks 2, 4, 6, 8, 10, 12
**Qty:** 8 **Refills:** 0
☐ ***Psoriatic Arthritis Induction:*** Inject 160 mg (2 x 80 mg) 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:** ☐

☐ **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.

## 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: | | |