BioPlus® Specialty Pharmacy
Carelon Company

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Dermatology (A-D)

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

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

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
SSN	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa ☐ Atopic Dermatitis ☐ Alopecia Areata ☐ Pruigo Nodularis ☐ Other: _____ **ICD-10** ***(Required)***

TB Test: ☐ No ☐ Yes
Date of Diagnosis: _____ / _____ / _____ Last TB Test Completed On: _____ / _____ / _____

Drug Allergies | Latex Allergy: ☐ No ☐ Yes

Weight ☐ kg ☐ lbs | Height ☐ ft ☐ in | Affected BSA | Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Adbry® *(tralokinumab-ldrm)*	☐ 150mg/mL PFS ☐ 300mg/2mL Pen	☐ Loading: Inject 600mg SUBQ for one dose ☐ Maintenance: ☐ Inject 300mg SUBQ every other week **OR** ☐ Inject 300mg SUBQ every 4 weeks	☐ 4 *(PFS)* ☐ 2 *(Pen)*	None
☐ Amjevita® *(adalimumab-atto)*	☐ 20mg/0.2mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL SureClick ☐ 40mg/0.8mL SureClick ☐ 80mg/0.8mL SureClick	**Psoriasis:** ☐ Loading: Inject 80mg SUBQ ☐ Maintenance: Inject 40mg SUBQ every other week starting 1 week after initial dose **Psoriatic Arthritis:** ☐ Maintenance: Inject 40mg SUBQ every other week **Hidradenitis Suppurativa (HS):** ☐ Loading: ☐ Inject 160mg SUBQ on day 1 **OR** ☐ Inject 80mg SUBQ on days 1 and 2, then 80mg SUBQ on day 15 ☐ Maintenance: ☐ Inject 40mg SUBQ once weekly **OR** ☐ Inject 80mg SUBQ every other week	_____ _____ _____ _____ _____	None _____ _____ None _____
☐ Bimzelx® *(bimekizumab-bkzx)*	☐ 160mg/mL PFS ☐ 320mg/2mL PFS ☐ 160mg/mL Pen ☐ 320mg/2mL Pen	**Psoriasis:** ☐ Loading: Inject 320mg SUBQ at week 0, 4, 8, 12, and 16 ☐ Maintenance: Inject 320mg SUBQ every 8 weeks **Hidradenitis Suppurativa (HS):** ☐ Loading: Inject 320mg SUBQ at weeks 0, 2, 4, 6, 8, 10, 12, 14, and 16, then every 4 weeks thereafter ☐ Maintenance: Inject 320mg SUBQ every 4 weeks ☐ **Bridge**	_____ _____ _____ _____	None _____ None _____
☐ Cibinqo™ *(abrocitinib)*	☐ 50mg Tablet ☐ 100mg Tablet ☐ 200mg Tablet	☐ _____mg PO once daily ☐ **Bridge**	_____	_____
☐ Cimzia® *(certolizumab pegol)*	☐ 200mg/mL PFS ☐ 400mg Vial	☐ Loading: Inject 2 x 200mg/mL SUBQ at weeks 0, 2, and 4 ☐ Maintenance: ☐ Inject 2 x 200mg SUBQ every 4 weeks **OR** ☐ Inject 2 x 200mg SUBQ every 2 weeks **OR** ☐ Inject 200mg SUBQ every 2 weeks	6 Syringes 28 Days	None _____
☐ Cosentyx® *(secukinumab)*	☐ 75mg PFS ☐ 150mg Sensoready® Pen Kit ☐ 150mg PFS ☐ 300mg UnoReady Pen *(1 x 300mg/2 mL)* ☐ 300mg Sensoready® Pen Kit *(2 x 150mg)* ☐ 300mg PFS *(2 x 150mg)*	**Psoriasis:** ☐ Loading: Inject 300mg SUBQ at weeks 0, 1, 2, 3, and 4 ☐ Maintenance: Inject 300mg SUBQ every 4 weeks **Psoriatic Arthritis:** ☐ Loading (optional): Inject 150mg SUBQ at weeks 0, 1, 2, 3, and 4 ☐ Maintenance: Inject 150mg SUBQ every 4 weeks **Hidradenitis Suppurativa (HS):** ☐ Loading: Inject 300mg SUBQ at weeks 0, 1, 2, 3, and 4 ☐ Maintenance: ☐ Inject 300mg SUBQ every 4 weeks **OR** ☐ Inject 300mg SUBQ every 2 weeks	QS 28 Days QS 28 Days _____ 28 Days	None _____ None _____ None _____
☐ Dupixent® *(dupilumab)*	☐ PFS ☐ Pen	☐ Loading: Inject 2 x 300mg (600mg) SUBQ day 1 ☐ Maintenance: Inject 300mg SUBQ every other week	2 for 14 Days 2 for 28 Days	None _____
☐ Other				

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

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Dermatology (E-L)

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

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
SSN	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa ☐ Atopic Dermatitis ☐ Alopecia Areata ☐ Pruigo Nodularis ☐ Other: _____ **ICD-10** ***(Required)***

TB Test: ☐ No ☐ Yes
Date of Diagnosis: _____ / _____ / _____ Last TB Test Completed On: _____ / _____ / _____

Drug Allergies			Latex Allergy: ☐ No ☐ Yes
Weight ☐ kg ☐ lbs	Height ☐ ft ☐ in	Affected BSA	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Ebglyss™ *(lebrikizumab-ibkz)*	☐ 250mg/2mL PFS ☐ 250mg/2mL Pen	☐ Loading: Inject 500mg (2 x 250mg) SUBQ at weeks 0 and 2 ☐ Induction: Inject 250mg SUBQ every 2 weeks (weeks 4-14) ☐ Maintenance: ☐ Inject 250mg SUBQ every 4 weeks starting week 16 **OR** ☐ Inject 250mg SUBQ every 8 weeks starting week 16 ☐ **Bridge**	4 2 1	None 2 _____
☐ Enbrel® *(etanercept)*	☐ Mini Cartridge ☐ PFS ☐ Autoinjector ☐ Vial	**Psoriasis:** ☐ Loading: Inject 50mg SUBQ twice weekly for 3 months ☐ Maintenance: ☐ Inject 50mg SUBQ once weekly **OR** ☐ Inject 50mg SUBQ twice weekly **Psoriatic Arthritis:** ☐ Maintenance: Inject 50mg SUBQ once weekly *Note: If new Mini Cartridge patient, complete and send Enbrel AutoTouch Order Form to KnipperRx.*	8 _____ 4	2 _____ _____
☐ Erivedge™ *(vismodegib)*	☐ 150mg Capsule	☐ Take once daily PO, with or without food	28 Days	_____
☐ Humira® *(adalimumab)*	☐ Pen ☐ PFS ☐ Citrate Free (CF)	**Psoriasis:** ☐ Loading: Inject 80mg SUBQ on day 1, 40mg SUBQ on days 8 and 22 ☐ Maintenance: Inject 40mg SUBQ every other week **Psoriatic Arthritis:** ☐ Maintenance: Inject 40mg SUBQ every other week **Hidradenitis Suppurativa (HS):** ☐ Loading: ☐ Inject 160mg SUBQ day 1, 80mg SUBQ day 15 **OR** ☐ Inject 80mg SUBQ day 1, 80mg SUBQ day 2, 80mg SUBQ day 15 ☐ Maintenance: ☐ Inject 40mg SUBQ once weekly, beginning day 29 **OR** ☐ Inject 80mg SUBQ every other week, beginning day 29 *Note: Use 40mg and/or 80mg devices as needed to meet insurance and dispensing requirements.*	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
☐ Icotyde™ *(icotrokinra)*	☐ 200mg Tablet	☐ Take 200mg PO once daily with water on an empty stomach upon waking	30	_____
☐ Ilumya™ *(tildrakizumab-asmn)*	☐ PFS	☐ Loading: Inject 100mg SUBQ at weeks 0 and 4 ☐ Maintenance: Inject 100mg SUBQ every 12 weeks	2 _____	None _____
☐ Inflectra® *(infliximab-dyyb)*	☐ 100mg Vials, 5mg/kg	☐ Loading: Give 5mg/kg IV infusion at weeks 0, 2, and 6 ☐ Maintenance: Give 5mg/kg IV infusion every _____ weeks	1 Dose _____	2 _____
☐ Leqselvi™ *(deuruxolitnib)*	☐ 8mg Tablet	☐ Take 8mg PO twice daily	_____	_____
☐ Litfulo™ *(ritlecitinib)*	☐ 50mg Capsule	☐ Take 50mg PO once daily ☐ **Bridge**	28	_____
☐ Other				

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

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Dermatology (M-R)

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Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
SSN	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa ☐ Atopic Dermatitis ☐ Alopecia Areata ☐ Pruigo Nodularis ☐ Other: _____ **ICD-10** ***(Required)***

TB Test: ☐ No ☐ Yes
Date of Diagnosis: _____ / _____ / _____ Last TB Test Completed On: _____ / _____ / _____

Drug Allergies — Latex Allergy: ☐ No ☐ Yes

Weight ☐ kg ☐ lbs	Height ☐ ft ☐ in	Affected BSA	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Nemluvio® *(nemolizumab-ilto)*	☐ 30mg Autoinjector	**Prurigo Nodularis:** ☐ Loading: Inject 60mg (2 x 30mg) SUBQ for first dose ☐ Maintenance: ☐ Weight <90kg: Inject 30mg SUBQ every 4 weeks **OR** ☐ Weight ≥ 90kg: Inject 60mg (2 x 30mg) SUBQ every 4 weeks **Atopic Dermatitis:** ☐ Loading: Inject 60mg (2 x 30mg) SUBQ for first dose ☐ Maintenance: ☐ Inject 30mg SUBQ every 4 weeks **OR** ☐ After week 16, inject 30mg SUBQ every 8 weeks	2 2	None None
☐ Odomzo® *(sonidegib)*	☐ 200mg Capsule	☐ Take 200mg PO once daily on an empty stomach, at least 1 hour before or 2 hours after a meal	30	
☐ Olumiant® *(baricitinib)*	☐ 2mg Tablet ☐ 4mg Tablet	☐ Take PO once daily ☐ **Bridge**		
☐ Otezla® *(apremilast)*	☐ 30mg Tablet	☐ Otezla® Titration Pack (Immediate Release): PO as directed per package instructions ☐ Maintenance: 30mg PO twice daily ☐ **Bridge**	1 Pack	None
☐ Otezla XR™ *(apremilast)*	☐ 75mg Tablet	☐ Otezla®/Otezla XR™ Titration Pack: PO as directed per package instructions ☐ Maintenance: 75mg PO once daily ☐ **Bridge**	1 Pack	None
☐ Remicade® *(infliximab)*	☐ 100mg Vial ☐ Biosimilar Authorized	☐ Loading: Give 5mg/kg IV infusion at weeks 0, 2, and 6 ☐ Maintenance: Give 5mg/kg IV infusion every _____ weeks	1 Dose	2
☐ Rinvoq® *(upadacitinib)*	☐ 15mg Extended-release Tablet ☐ 30mg Extended-release Tablet	☐ Take once daily PO with or without food		
☐ Rhapsido® *(remibrutinib)*	☐ 25mg Tablet	☐ Take 25mg PO twice daily ☐ **Bridge**		
☐ Other				

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

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Dermatology (S-Z)

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Patient Information

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Main Phone	Alternate Phone
SSN	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Hidradenitis Suppurativa ☐ Atopic Dermatitis ☐ Alopecia Areata ☐ Pruigo Nodularis ☐ Other: _____ **ICD-10** ***(Required)***

TB Test: ☐ No ☐ Yes
Date of Diagnosis: _____ / _____ / _____ Last TB Test Completed On: _____ / _____ / _____

Drug Allergies — Latex Allergy: ☐ No ☐ Yes

Weight ☐ kg ☐ lbs | Height ☐ ft ☐ in | Affected BSA | Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Siliq® *(brodalumab)*	☐ PFS	☐ Loading: Inject 210mg SUBQ at weeks 0 and 1 ☐ Maintenance: Starting at week 2, inject 210mg SUBQ every 2 weeks	2 2	None _____
☐ Simlandi® *(adalimumab-ryvk)*	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL Pen ☐ 80mg/0.8mL PFS ☐ 80mg/0.8mL Pen	**Psoriasis:** ☐ Loading: Inject 80mg SUBQ on day 1 ☐ Maintenance: Inject 40mg SUBQ every other week starting on day 8 **Psoriatic Arthritis:** ☐ Maintenance: Inject 40mg SUBQ every other week **Hidradenitis Suppurativa (HS):** ☐ Loading: ☐ Inject 160mg SUBQ on day 1, then 80mg on day 15 **OR** ☐ Inject 80mg SUBQ on days 1 and 2, then 80mg on day 15 ☐ Maintenance: ☐ Inject 40mg SUBQ once weekly **OR** ☐ Inject 80mg SUBQ every other week	_____ _____ _____ _____ _____	_____ None _____ _____ _____
☐ Simponi® *(golimumab)*	☐ PFS ☐ Autoinjector	☐ Inject 50mg SUBQ once a month	1	_____
☐ Simponi Aria® *(golimumab)*	☐ 50mg/4mL Vial	☐ Loading: Infuse 2mg/kg IV at weeks 0 and 4 ☐ Maintenance: Infuse 2mg/kg IV every 8 weeks	2 _____	None _____
☐ Skyrizi® *(risankizumab-rzaa)*	☐ PFS ☐ Pen	☐ Loading: Inject 150mg SUBQ at weeks 0 and 4 ☐ Maintenance: Inject 150mg SUBQ every 12 weeks	2 Syringes _____	_____ _____
☐ Stelara® *(ustekinumab)*	☐ 45mg PFS ☐ 90mg PFS	☐ Loading: ☐ Weight ≤ 100kg: Inject 45mg SUBQ at weeks 0 and 4 **OR** ☐ Weight > 100kg: Inject 90mg SUBQ at weeks 0 and 4 ☐ Maintenance: ☐ Weight ≤ 100kg: Inject 45mg SUBQ every 12 weeks **OR** ☐ Weight > 100kg: Inject 90mg SUBQ every 12 weeks	2 1	None _____
☐ Sotyktu™ *(deucravacitinib)*	☐ 6mg Tablet	☐ Take 6mg once daily PO with or without food	_____	_____
☐ Taltz® *(ixekizumab)*	☐ Autoinjector ☐ PFS	**Psoriasis:** ☐ Loading: Inject 160mg (2 x 80mg) SUBQ at week 0 and 80mg SUBQ at week 2 ☐ Induction: Inject 80mg SUBQ at weeks 4, 6, 8, 10, and 12 ☐ Maintenance: Inject 80mg SUBQ every 4 weeks **Psoriatic Arthritis:** ☐ Loading: Inject 160mg (2 x 80mg) SUBQ at week 0 ☐ Maintenance: Inject 80mg SUBQ every 4 weeks ☐ **Bridge**	3 2 _____ 2 _____	None 1 _____ None _____
☐ Tremfya® *(guselkumab)*	☐ Autoinjector ☐ PFS	☐ Loading: Inject 100mg SUBQ at weeks 0 and 4 ☐ Maintenance: Inject 100mg SUBQ every 8 weeks	2 1	None _____
☐ Other				

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