BioPlus® Specialty Pharmacy
A Carelon Company

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

DERMATOLOGY

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:** ____

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-lbkz)* ☐ 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 Starter:
☐ 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 Starter:*** 80 mg SUBQ Day 1, 40 mg SUBQ Day 8, 40 mg SUBQ Day 22
Qty: 1 Pack **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: 28 days **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

LITFULO™ *(ritlecitinib)* capsule ☐ 50 mg PO once daily
Qty: 28 **Refills:** ____

NEMLUVIO® *(nemolizumab-ilto)* PFS ☐ 30 mg/mL
☐ **Induction:** Inject 60 mg/mL (2 x 30 mg/mL) SUBQ
Qty: 2 **Refills:** None
☐ **Maintenance:** Inject 30 mg/mL SUBQ every 4 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
☐ **Bridge Pack:** PO as directed per package instructions
Qty: 1 Pack **Refills:** ____
☐ **Maintenance:** (30 mg) PO twice daily
Qty: 30 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:** ____

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. ☐ 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:		