BioPlus
A CenterWell Company

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RHEUMATOLOGY

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

PATIENT INFORMATION

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

CLINICAL INFORMATION

Diagnosis: ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Juvenile Rheumatoid Arthritis ☐ Iridocyclitis (Uveitis) ☐ Other:_____

Allergies:	Weight:	Height:

TB Test Result:	Date:	HepB Test Result:	Date:

Prior Failed Meds: ☐ Actemra® ☐ Cimzia® ☐ Cosentyx® ☐ Enbrel® ☐ Humira® ☐ Kevzara® ☐ Orencia® ☐ Otezla® ☐ Other: _____

Prior Methotrexate/Oral Systemic Medications: ☐ Yes ☐ No ☐ Contraindicated

INSURANCE INFORMATON (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

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

ACTEMRA® *(tocilizumab)*
☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL
☐ 162 mg/0.9 mL PFS ☐ 162 mg/0.9 mL pen
☐ **Infuse** (☐ 4 mg/kg ☐ 8 mg/kg) IV every 4 weeks
☐ **Inject** 162 mg SUBQ (☐ Every other week ☐ Every week)
Qty: **Refills:**

AMJEVITA™ *(adalimumab-atto)* ☐ SureClick 40 mg/0.8 mL
☐ PFS 20 mg/0.4 mL ☐ PFS 40 mg/0.8 mL
☐ **Inject** 40 mg every other week and ____ mg every other week
Qty: **Refills:**

BENLYSTA® *(belimumab)* Vials: ☐ 120 mg ☐ 400 mg
200 mg ☐ AutoInjector ☐ PFS
☐ **Infuse** _____ mg (10 mg/kg/dose) IV at weeks 0, 2, 4, then every 4 weeks thereafter
☐ **Maintenance:** Infuse _____mg (10 mg/kg/dose) IV every 4 weeks
☐ **Induction:** Inject 400 mg SUBQ once weekly for 4 doses then 200 mg SUBQ once a week thereafter.
☐ **Maintenance**: Inject 200 mg SUBQ once a week
Qty: 4 Week Supply **Refills:**

BIMZELX® *(bimekizumab-bkzx)* 160 mg ☐ PFS ☐ Pen
☐ Inject 160 mg SUBQ every 4 weeks
Qty: 1 **Refills:**

CIMZIA® *(certolizumab pegol)* PFS
Induction: ☐ Inject 100 mg SUBQ at weeks 2 and 4
☐ Inject 400 mg (2 x 200 mg) SUBQ at weeks 0, 2, and 4
Qty: 6 **Refills:**
Maintenance: ☐ 50 mg SUBQ every other week
☐ 100 mg SUBQ every other week
☐ 200 mg SUBQ every 2 weeks
☐ 400 mg (2 x 200 mg) SUBQ every 4 weeks
☐ 400 mg (2 x 200 mg) SUBQ every 2 weeks
Qty: **Refills:**

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

ENBREL® *(etanercept)*
☐ Mini cartridge ☐ PFS
☐ AutoInjector ☐ Vial
☐ 25 mg ☐ 50 mg
☐ Once weekly SUBQ ☐ Twice weekly SUBQ
Qty: ☐ 4 ☐ 8 **Refills:**

HUMIRA® *(adalimumab)*
☐ Pen ☐ PFS
☐ Citrate free (CF) ☐ Original formula
☐ 40 mg SUBQ every other week
☐ 40 mg SUBQ once a week
Qty: 28 days **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:**
☐ **Maintenance:** Give dose as an IV infusion every __ weeks
Qty: **Refills:**

KEVZARA® *(sarilumab)* ☐ Pen ☐ PFS
☐ 150 mg ☐ 200 mg
Dosing: Inject SUBQ every 2 weeks.
Qty: 2 **Refills:**

OLUMIANT® *(baricitinib)* ☐ 1 mg tablet ☐ 2 mg tablet
☐ Take 1 tablet PO daily
Qty: **Refills:**
☐ Bridge*

ORENCIA® *(abatacept)*
☐ 125 mg PFS ☐ 250 mg vial ☐ 125 mg autoinjector
☐ Inject 125 mg SUBQ once a week.
☐ Infuse ___mg IV at Weeks 0, 2, and 4 then every 4 weeks
Qty: 4 week supply **Refills:**

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

REMICADE® *(infliximab)* 100 mg vials ☐ Biosimilar authorized
☐ 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:**

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

SIMLANDI® *(adalimumab-ryvk)* 40 mg PFS
☐ Inject SUBQ 40 mg every other week
Qty: 1 **Refills:**

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

SKYRIZI™ (risankizumab-rzaa)
☐ PFS ☐ Pen
☐ Inject 150 mg (1 injection) SUBQ at Week 0, Week 4, and then every 12 weeks
Qty: 1 **Refills:**

STELARA® *(ustekinumab)*
☐ 45 mg PFS ☐ 90 mg PFS
Inject contents of 1 syringe SUBQ on day 0, then week 4, then every 12 weeks
Qty: 1 **Refills:**

TALTZ® *(ixekizumab)*
☐ Autoinjector ☐ PFS ☐ Citrate free (CF)
☐ **Psoriasis Induction:** Inject 160 mg (2 x 80 mg injections) SUBQ at week 0; Inject 80 mg at weeks 2, 4, 6, 8 ,10, 12
Qty: 8 **Refills:**
☐ **Psoriatic Arthritis Induction**: Inject 160 mg (2 x 80 mg injections) SUBQ at week 0
Qty: 2 **Refills:** 0
☐ **Maintenance:** 80 mg SUBQ every 4 weeks
Qty: 1 **Refills:**
☐ Bridge*

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:**

XELJANZ® *(tofacitinib)*
☐ 5 mg tablet ☐ 11 mg XR tabs
☐ Take one 5 mg tablet PO twice daily
☐ Take one 11 mg tablet PO once daily
Qty: **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:		