BioPlus® Specialty Pharmacy
A Carelon Company

Pediatric Rheumatology A-M

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

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
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

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

Clinical Information

Diagnosis: ☐ M08.0 Juvenile Idiopathic Arthritis ☐ H20.9 Uveitis ☐ L40.50 Psoriatic Arthritis
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
☐ Other: _____

Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____
_____ Length of Treatment: _____ Reason for Discontinuing: _____
_____ Length of Treatment: _____ Reason for Discontinuing: _____

Drug Allergies		Latex Allergy: ☐ No ☐ Yes
Weight ☐ kg ☐ lbs	TB Test: ☐ No ☐ Yes Date: _____ Results: ☐ Negative ☐ Positive (please send lab results)	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Actemra®	162 mg ☐ Autoinjector ☐ PFS Vials: ☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL	**Polyarticular Juvenile Idiopathic Arthritis** Subcutaneous: ☐ Inject 162 mg SUBQ every 3 weeks (<30 kg) ☐ Inject 162 mg SUBQ every 2 weeks (≥30 kg) Intravenous: ☐ Infuse _____ mg (10 mg/kg) every 4 weeks (<30 kg) ☐ Infuse _____ mg (8 mg/kg) every 4 weeks (≥30 kg) **Systemic Juvenile Idiopathic Arthritis** Subcutaneous: ☐ Inject 162 mg SUBQ every 2 weeks (30 kg) ☐ Inject 162 mg SUBQ every week (≥30 kg) Intravenous: ☐ Infuse _____ mg (12 mg/kg) every 2 weeks (<30 kg) ☐ Infuse _____ mg (8 mg/kg) every 2 weeks (≥30 kg)	4 Week Supply	_____
☐ Benlysta®	200 mg ☐ Autoinjector ☐ PFS Vials: ☐ 120 mg ☐ 400 mg	☐ Inject 200 mg SUBQ once a week ☐ Load: Infuse _____ mg (10 mg/kg) at weeks 0, 2, and 4, then every 4 weeks thereafter ☐ Maintenance: Infuse _____ mg (10 mg/kg) every 4 weeks	4 Week Supply Loading Dose 4 Week Supply	_____ None _____
☐ Cosentyx®	☐ 75mg PFS 150mg ☐ Pen ☐ PFS	☐ Load: Inject 75 mg SUBQ on week 0, 1, 2, 3 (≥15 kg to <50 kg) ☐ Maintenance: Inject 75 mg SUBQ on week 4, then every 4 weeks therafter (≥15 kg to <50 kg) ☐ Load: Inject 150 mg SUBQ on week 0, 1, 2, 3 (≥50 kg) ☐ Maintenance: Inject 150 mg SUBQ on week 4, then every 4 weeks thereafter (≥50 kg)	4 Week Supply 4 Week Supply 4 Week Supply 4 Week Supply	None _____ None _____
☐ Enbrel®	50 mg ☐ SureClick® ☐ PFS ☐ Mini ☐ 25 mg PFS ☐ 25 mg/0.5 mL SDV	☐ Inject 50 mg SUBQ once a week (≥63 kg) ☐ Inject 25 mg SUBQ once a week ☐ Inject _____ mg (0.8 mg/kg) SUBQ once a week (<63 kg)	4 Week Supply 4 Week Supply 4 Week Supply	_____ _____ _____
☐ Humira® Citrate Free	☐ 10 mg PFS ☐ 20 mg PFS 40 mg ☐ PFS ☐ Pen	☐ Inject 10 mg SUBQ every other week (10 kg to <15 kg) ☐ Inject 20 mg SUBQ every other week (15 kg to <30 kg) ☐ Inject 40 mg SUBQ every other week (≥30 kg)	4 Week Supply	_____
☐ Other				

Prescriber's Signature (no stamps) **Substitution Permitted** _____ **Date** _____

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

BioPlus® Specialty Pharmacy
A Carelon Company

Pediatric Rheumatology N-Z

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

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
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

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

Clinical Information

Diagnosis: ☐ M08.0 Juvenile Idiopathic Arthritis ☐ H20.9 Uveitis ☐ L40.50 Psoriatic Arthritis
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
☐ Other: _____

Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____
_____ Length of Treatment: _____ Reason for Discontinuing: _____
_____ Length of Treatment: _____ Reason for Discontinuing: _____

Drug Allergies		Latex Allergy: ☐ No ☐ Yes
Weight ☐ kg ☐ lbs	TB Test: ☐ No ☐ Yes Date: _____ Results: ☐ Negative ☐ Positive (please send lab results)	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information			Qty	Refills
☐ Orencia®	☐ 50 mg PFS ☐ 87.5 mg PFS ☐ 125 mg PFS ☐ 250 mg Vial	☐ Inject 50 mg SUBQ weekly (10 kg to <25 kg) ☐ Inject 87.5 mg SUBQ weekly (25 kg to <50 kg) ☐ Inject 125 mg SUBQ weekly (≥50 kg) ☐ Load: Infuse 1000 mg IV at weeks 0, 2, 4, then every 4 weeks thereafter (>100 kg) ☐ Load: Infuse 750 mg IV at weeks 0, 2, 4, then every 4 weeks thereafter (75 kg to 100 kg) ☐ Load: Infuse _____ mg (10 mg/kg) IV at weeks 0, 2, 4, then every 4 weeks thereafter (<75 kg) ☐ Maintenance: Infuse _____ mg IV every 4 weeks	4 Week Supply Loading Dose 4 Week Supply	_____ None _____
☐ Rinvoq®	☐ 1 mg/mL Oral Solution ☐ 15 mg ER Tablet	☐ Take 3 mL by mouth twice daily (10 kg to <20 kg) ☐ Take 4 mL by mouth twice daily (20 kg to <30 kg) ☐ Take 6 mL by mouth twice daily (≥30 kg) ☐ Take 1 tablet by mouth once daily (≥30 kg)	4 Week Supply 4 Week Supply 4 Week Supply 30 Tablets	_____ _____ _____ _____
☐ Stelara® Psoriatic Arthritis	☐ 45 mg Vial (<60 kg)	☐ Starter: Inject _____ mg (0.75 mg/kg) SUBQ on week 0 ☐ Maintenance: Inject _____ mg (0.75 mg/kg) SUBQ on week 4, then every 12 weeks thereafter	1 Vial 1 Vial	None _____
	☐ 45 mg PFS (≥60 kg) ☐ 90 mg PFS (>100 kg with Ps)	☐ Starter: Inject 1 syringe SUBQ on week 0 ☐ Maintenance: Inject 1 syringe SUBQ on week 4, and then every 12 weeks thereafter	1 Syringe 1 Syringe	None _____
☐ Xeljanz®	☐ 1 mg/mL Oral Solution ☐ 5 mg Tablet	☐ Take 3.2 mL by mouth twice daily (10 kg to <20 kg) ☐ Take 4 mL by mouth twice daily (20 kg to <40 kg) ☐ Take 5 mL by mouth twice daily (≥40 kg) ☐ Take 5 mg by mouth twice daily (≥40 kg)	4 Week Supply 4 Week Supply 4 Week Supply 60 Tablets	_____ _____ _____ _____
☐ Other				

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

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