BioPlus® Specialty Pharmacy
A Carelon Company

Pediatric Dermatology A-G

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: ☐ L20.9 Atopic Dermatitis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa - Hurley Stage: _____
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
Skin: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____ % BSA: _____

Prior Failed Meds: ☐ Biologics: _____ ☐ Oral: _____
☐ Topical: _____ ☐ Other: _____

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
☐ Adbry® *12+ Years Old	150 mg PFS	☐ Load: Inject 300 mg (as two-150 mg injections) SUBQ on Day 1, then inject 150 mg SUBQ every other week starting on Day 15 ☐ Maintenance: Inject 150 mg SUBQ every other week starting on Day 15	2 Syringes 2 Syringes	None _____
☐ Cibinqo™ *12+ Years Old	☐ 50 mg ☐ 100 mg ☐ 200 mg	☐ Take 1 tablet by mouth once daily	30 Tablets	_____
☐ Cosentyx®	☐ 75 mg PFS 150 mg ☐ Pen ☐ PFS	☐ Load: Inject 75 mg SUBQ on week 0, 1, 2, 3 (<50 kg) ☐ Maintenance: Inject 75 mg SUBQ on week 4, then every 4 weeks thereafter (<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 _____
☐ Dupixent® *Age 6 Months-5 Years Old	☐ 200 mg PFS w/Shield ☐ 200 mg Pen (2+ years old)	☐ Inject 200 mg SUBQ every 4 weeks (5 kg to <15 kg)	2 Syringes	_____
	☐ 300 mg PFS w/Shield ☐ 300 mg Pen (2+ years old)	☐ Inject 300 mg SUBQ every 4 weeks (15 kg to <30 kg)	2 Syringes	_____
☐ Dupixent® *Age 6-17 Years Old	☐ 300 mg PFS w/Shield ☐ 300 mg Pen	☐ Load: Inject 600 mg (as two-300 mg injections in different sites) on Day 1, then 300 mg every 4 weeks starting on Day 29 (15kg to <30kg) ☐ Maintenance: Inject 300 mg SUBQ once every 4 weeks starting on Day 29 (15 kg to <30 kg)	2 Syringes 2 Syringes	None _____
	☐ 200 mg PFS w/Shield ☐ 200 mg Pen	☐ Load: Inject 400 mg (as two-200 mg injections in different sites) on Day 1, then 200 mg every other week starting on Day 15 (30 kg to <60 kg) ☐ Maintenance: Inject 200 mg SUBQ once every other week starting on Day 15 (30 kg to <60 kg)	2 Syringes 2 Syringes	None _____
	☐ 300 mg PFS w/Shield ☐ 300 mg Pen	☐ Load: Inject 600 mg (as two-300 mg injections in different sites) on Day 1, then 300 mg every other week starting on Day 15 (≥60 kg) ☐ Maintenance: Inject 300 mg SUBQ every other week starting on Day 15 (≥60 kg)	2 Syringes 2 Syringes	None _____
☐ Ebglyss™ *12+ Years Old: ≥40 kg	☐ 250 mg Pen ☐ 250 mg PFS	☐ Initial: Inject 500 mg (as two-250 mg injections) SUBQ at week 0 and week 2 ☐ Induction: Inject 250 mg SUBQ every 2 weeks (weeks 4-14). If additional induction dosing is needed, contact the pharmacy. ☐ Maintenance: Inject 250 mg SUBQ every 4 weeks, starting week 16.	4 Injections 2 Injections 1 Injection	None 2 _____
☐ 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) subcutaneously once a week (<63 kg)	4 Week Supply 4 Week Supply 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 Dermatology H-O

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: ☐ L20.9 Atopic Dermatitis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa - Hurley Stage: _____
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
Skin: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____ % BSA: _____

Prior Failed Meds: ☐ Biologics: _____ ☐ Oral: _____
☐ Topical: _____ ☐ Other: _____

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
☐ Humira® HS Citrate Free *Adol: 30 kg-59 kg	☐ PsO/UV Starter Pkg (Pens only) 40 mg ☐ Pen ☐ PFS	☐ Load: Inject 80 mg SUBQ on Day 1, then 40 mg on Day 8, then 40 mg every other week thereafter ☐ Maintenance: Inject 40 mg SUBQ every other week	Loading Dose 4 Week Supply	None _____
☐ Humira® HS Citrate Free *Adol: ≥60 kg	☐ HS Starter Pkg (Pens only) 40 mg ☐ Pen ☐ PFS	☐ Load: Inject 160 mg SUBQ as ☐ two-80 mg injections on Day 1 **or** ☐ one-80 mg injection on Day 1 and then Day 2, then inject 80 mg on Day 15, then inject 40 mg every week thereafter starting on Day 29 ☐ Maintenance: Inject 40 mg SUBQ every week	Loading Dose 4 Week Supply	None _____
☐ Humira® HS Citrate Free *HS Adol: ≥6 0kg	☐ HS Starter Pkg (Pens only) ☐ 80 mg Pen	☐ Load: Inject 160 mg SUBQ as ☐ two-80 mg injections on Day 1 **or** ☐ one-80 mg injection on Day 1 and then Day 2, then inject 80 mg on Day 15, then inject 80 mg every other week thereater starting on Day 29 ☐ Maintenance: Inject 80 mg SUBQ every other week	Loading Dose 4 Week Supply	None _____
☐ Litfulo™ *12+ Years Old	50 mg Capsule	☐ Take 1 capsule by mouth once daily	28 Capsules	_____
☐ Nemluvio® *12+ Years Old	30 mg Pen	☐ Load: Inject 60 mg (as two-30 mg pens) SUBQ at week 0 ☐ Maintenance: Inject 30 mg (1 pen) SUBQ every 4 weeks	2 Pens 1 Pen	None _____
☐ Otezla® *20 kg to <50 kg	☐ 10 mg-20 mg Starter Pack ☐ 20 mg Tablet	☐ Take 1 tablet by mouth on Day 1 then twice daily as directed **or** date provided _____ ☐ Take 1 tablet by mouth twice daily For Bridge Requests please utilize the Otezla Support Plus Start Form and fax to BioPlus Specialty Pharmacy at 800-269-5493	1 Starter Pack 60 Tablets	None _____
☐ Otezla® *≥50 kg	☐ 10 mg-20 mg-30 mg Starter Pack ☐ 30 mg Tablet	☐ Take 1 tablet by mouth on Day 1 then twice daily as directed **or** date provided _____ ☐ Take 1 tablet by mouth twice daily For Bridge Requests please utilize the Otezla Support Plus Start Form and fax to BioPlus Specialty Pharmacy at 800-269-5493	1 Starter Pack 60 Tablets	None _____
☐ 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 Dermatology P-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: ☐ L20.9 Atopic Dermatitis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa - Hurley Stage: _____
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
Skin: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____ % BSA: _____

Prior Failed Meds: ☐ Biologics: _____ ☐ Oral: _____
☐ Topical: _____ ☐ Other: _____

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
☐ Rinvoq® *12+ Years Old; ≥40 kg	☐ 15 mg ER Tablet ☐ 30 mg ER Tablet	☐ Take 1 tablet by mouth once daily	30 Tablets	_____
☐ Stelara® Psoriasis	☐ 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 to ≤100 kg) ☐ 90 mg PFS (>100 kg)	☐ 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 _____
☐ 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 _____
☐ Taltz®	☐ 40 mg PFS ☐ 20 mg PFS	☐ Starter: Inject 40 mg SUBQ on Day 1 (<25 kg) ☐ Maintenance: Inject 20 mg SUBQ every 4 weeks thereafter (<25 kg)	1 Syringe 1 Syringe	None _____
	☐ 80 mg PFS ☐ 40 mg PFS	☐ Starter: Inject 80 mg SUBQ on Day 1 (25 kg to 50 kg) ☐ Maintenance: Inject 40 mg SUBQ every 4 weeks thereafter (25 kg to 50 kg)	1 Syringe 1 Syringe	None _____
	80 mg ☐ Pen ☐ PFS	☐ Starter: Inject 160 mg (as two-80 mg injections) SUBQ on Day 1 (>50 kg) ☐ Maintenance: Inject 80 mg SUBQ every 4 weeks thereafter (>50 kg)	2 Syringes 1 Syringe	None _____
☐ Other				

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

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