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Dermatology (A-D)

Phone: 832-886-4296 **Fax:** 832-886-4298 zarinapharmacy.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 QS	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				

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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)*	☐ PFS ☐ Pen	**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	QS _____	2 _____
☐ Leqselvi™ *(deuruxolitnib)*	☐ 8mg Tablet	☐ Take 8mg PO twice daily	_____	_____
☐ Litfulo™ *(ritlecitinib)*	☐ 50mg Capsule	☐ Take 50mg PO once daily ☐ **Bridge**	28	_____
☐ Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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Dermatology (M-R)

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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
☐ 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	QS _____	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				

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Dermatology (S-Z)

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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

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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 _____ 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	QS _____	None _____
☐ Skyrizi® *(risankizumab-rzaa)*	☐ PFS ☐ Pen	☐ Loading: Inject 150mg SUBQ at weeks 0 and 4 ☐ Maintenance: Inject 150mg SUBQ every 12 weeks	2 _____	_____ _____
☐ 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)*	☐ PFS ☐ Autoinjector	**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)*	☐ PFS ☐ One-Press ☐ Pen	☐ Loading: Inject 100mg SUBQ at weeks 0 and 4 ☐ Maintenance: Inject 100mg SUBQ every 8 weeks	2 1	None _____
☐ Other				

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