

Creon Prescription Referral Form



Phone: 843.352.7662 | Fax 833.898.3992 | Backup Fax 843.352.7632 | 1501 Belle Isle Ave #150 Mt. Pleasant SC 29464

PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: _____ Last Name: _____ Date of Birth: _____ M F
 Street Address: _____ City: _____ State: _____ Zip: _____
 Cell Phone: _____ SSN: _____ Patient Preferred Language: English Spanish _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
 Address: _____
 Phone Number: _____ Fax Number: _____ Contact Person: _____

PATIENT CLINICAL INFORMATION / HISTORY

(PLEASE ATTACH COPY OF MOST RECENT CHART NOTES, PATHOLOGY, AND LABS)

Patient Weight	MINIMUM per-meal dose	MAXIMUM per-meal dose
110lb (49.9kg)	36,000 Lipase Units	108,000 Lipase Units
130lb (59.0kg)	36,000 Lipase Units	144,000 Lipase Units
160lb (72.6kg)	72,000 Lipase Units	180,000 Lipase Units
200lb (90.7kg)	72,000 Lipase Units	216,000 Lipase Units
230lb (104.3kg)	72,000 Lipase Units	252,000 Lipase Units

Other Notes: _____

PRESCRIBING INFORMATION

STRENGTH	SIG	QTY	REFILLS
<input type="checkbox"/> 36,000 Lipase Units <input type="checkbox"/> 24,000 Lipase Units <input type="checkbox"/> 12,000 Lipase Units <input type="checkbox"/> 6,000 Lipase Units <input type="checkbox"/> 3,000 Lipase Units	Take _____ capsules during each meal Take _____ capsules during each snack Take during every meal and snack		

PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I authorize Blue Sky Specialty Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process/appeals if necessary, in doing so, to release clinical information via phone/fax to appropriate third party payor.