Gastroenterology – Non Specialty
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: ___________________

Office's Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Portal ☐ Email: ________________ ☐ Other: ______________

PATIENT CLINICAL INFORMATION / HISTORY – PLEASE FORWARD CHART NOTES AND RELEVANT LABS

Diagnosis: _______________________ ICD 10: __________ Weight:_______ Height: _______ Drug Allergies:________________

Previous / Failed Medications:____

Notes:____

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver medication to patient ☐ Deliver medication to MD

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ ALINIA	☐ 500mg Tablet	☐ Take 1 tablet by mouth twice daily		
☐ CREON	☐ _________ Lipase Units	☐ Take _____ capsules during each meal and _____ during each snack		
☐ DIFICID	☐ 200mg Tablet	☐ Take 200mg by mouth twice daily	20	0
☐ IBSRELA	☐ 50mg Tablet	☐ Take 50mg by mouth twice daily		
☐ TALICIA	☐ 10mg/250mg/12.5mg Capsules	☐ Take 4 capsules by mouth three times a day for 14 days	168	
☐ VEMLIDY	☐ 25mg Tablet	☐ Take 1 tablet by mouth once daily		
☐ XIFAXAN	☐ 550mg Tablet	☐ Irritable Bowel Syndrome; Take 1 tablet by mouth three times a day	42	
		☐ Hepatic Encephalopathy; Take 1 tablet by mouth twice daily		

PRESCRIPTION SIGNATURE

Dispense as Written: ________________________________ Substitution Permitted: _______________________________ Date: __________________

I Authorize Blue Sky Specialty Pharmacy and it's 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.

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