

# Gastroenterology - 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:  K50.9 (Crohns)  K51.90 (UC)  \_\_\_\_\_  
 Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Tb Test Results: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Latex Allergy  Yes  No  
 Previous / Failed Medications: \_\_\_\_\_ Drug Allergies: \_\_\_\_\_

## PRESCRIBING INFORMATION

NEW  RESTART  CONTINUING | SHIPPING PREFERENCE:  Deliver medication to patient  Deliver medication to MD for first fill

MEDICATION	DOSAGE	SIG	QTY	REFILLS
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200mg PFS (2 x 200) <input type="checkbox"/> 200 LYO Powder (2 x 200)	<input type="checkbox"/> <u>Induction Dose</u> : Inject 400mg SC at weeks 0, 2, and 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 400mg SC every 4 weeks	6	0
<input type="checkbox"/> ENTYVIO	<input type="checkbox"/> 300mg Vial	<input type="checkbox"/> <u>Induction Dose</u> : Infuse 300mg via IV over 30 minutes at weeks 0, 2, and 6 <input type="checkbox"/> <u>Maintenance Dose</u> : Infuse 300mg via IV over 30 minutes 8 weeks after 3 induction doses and continue every 8 weeks	3 1	0
<input type="checkbox"/> HUMIRA (Citrate Free)	<input type="checkbox"/> Crohns/UC Starter (80mg/0.8mL Pen) <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 80mg/0.8mL Pen <input type="checkbox"/> 80mg/0.8mL PFS	<input type="checkbox"/> Inject 160mg SC on day 1, then inject 80mg SC on day 15 <input type="checkbox"/> Inject 80mg SC on day 1, then inject 80mg SC on day 2, then inject 80mg SC on day 15 <input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Inject 40mg SC once weekly <input type="checkbox"/> Inject 80mg SC every other week	3 3	0 0
<input type="checkbox"/> REMICADE	<input type="checkbox"/> 100mg Vial Weight: _____	<input type="checkbox"/> <u>Induction Dose</u> : Infuse _____mg/kg via IV at week 0, week 2, and week 6 <input type="checkbox"/> <u>Maintenance Dose</u> : Infuse _____mg/kg via IV every 8 weeks		
<input type="checkbox"/> RINVOQ	<input type="checkbox"/> 15mg Tablet <input type="checkbox"/> 30mg Tablet <input type="checkbox"/> 45mg Tablet	<input type="checkbox"/> <u>Induction Dose</u> : Take 45mg by mouth once daily for 8 weeks <input type="checkbox"/> <u>Maintenance Dose</u> : Take _____mg by mouth once daily		
<input type="checkbox"/> SIMPONI	<input type="checkbox"/> 100mg Smartject <input type="checkbox"/> 100mg PFS	<input type="checkbox"/> <u>Induction Dose</u> : Inject 200mg SC at week 0, then inject 100mg SC at week 2 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 100mg SC once every 4 weeks	4	0
<input type="checkbox"/> STELARA	<input type="checkbox"/> 130mg/26mL Vial <input type="checkbox"/> 90mg/mL PFS	<input type="checkbox"/> Infuse _____mg via IV as a single dose over 60 minutes <input type="checkbox"/> Inject 90mg SC 8 weeks after initial IV dose, then every 8 weeks thereafter		
<input type="checkbox"/> XELJANZ/XR	<input type="checkbox"/> 10mg Tablet <input type="checkbox"/> 5mg Tablet <input type="checkbox"/> 22mg Tablet <input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> <u>Induction Dose</u> : Take 10mg by mouth twice daily for _____ week(s) <input type="checkbox"/> <u>Maintenance Dose</u> : Take 5mg by mouth twice daily <input type="checkbox"/> <u>Induction Dose</u> : Take 22mg by mouth once daily for _____ week(s) <input type="checkbox"/> <u>Maintenance Dose</u> : Take 11mg by mouth once daily		
<input type="checkbox"/> ZEPOSIA	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 0.92mg Capsule	<input type="checkbox"/> <u>Titration</u> : Take 0.23mg by mouth on week 0 and advance as directed <input type="checkbox"/> <u>Maintenance Dose</u> : Take 0.92mg by mouth once daily	7	7

## 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.

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.