Dermatology Prescription Referral Form

A-O

blue sky SPECIALTY PHARMACY

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: _____ Tb Test Results: _____

Drug Allergies:_____ BSA%: ____ Previous / Failed Medications:_____

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ ADBRY	☐ 150mg/mL PFS	☐ Induction Dose: Inject 600mg SC on day 1	4	0
		☐ Maintenance Dose: Inject 300mg SC every _____ weeks		
☐ CIBINQO	☐ 100mg Tablet ☐ 50mg Tablet ☐ 200mg Tablet	☐ Take_____ mg by mouth once daily		
☐ CIMZIA Weight:_____	☐ 200mg/mL Starter Kit ☐ 200mg/mL PFS	☐ Induction Dose (if ≤90kg): Inject 400mg SC on week 0, at weeks 2 and week 4 ☐ Maintenance Dose: Inject _____ mg SC every other week	3	0
☐ COSENTYX	☐ 150mg/mL PFS ☐ 150mg/mL Sensoready	☐ Induction Dose: Inject 300mg SC on weeks 0, 1, 2, 3, and 4. ☐ Maintenance Dose: Inject 300mg SC every 4 weeks	10	0
☐ DUPIXENT	☐ 300mg/2mL PFS ☐ 300mg/2mL Pen	☐ Induction Dose: Inject 600mg SC on day 1 ☐ Maintenance Dose: Inject 300mg SC every 2 weeks thereafter	4	0
	☐ 200mg/1.14mL PFS	☐ Induction Dose: Inject 400mg SC on day 1 ☐ Maintenance Dose: Inject 200mg SC every 2 weeks thereafter		
☐ ENBREL	☐ 50mg Mini ☐ 50mg/mL PFS ☐ 50mg/mL SureClick	☐ Induction Dose (Psoriasis): Inject 50mg SC twice weekly for 12 weeks ☐ Maintenance Dose: Inject 50mg SC once weekly	8	2
☐ HUMIRA	☐ Psoriasis Starter Kit ☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL Pen ☐ HS Starter Kit	☐ Induction Dose: Inject 80mg SC on day 1, then inject 40mg SC on day 8, and inject 40mg SC on day 22 ☐ Maintenance Dose: Inject 40mg SC every 2 weeks ☐ Other:_____	3	0
	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL Pen ☐ 80mg/0.8mL PFS ☐ 80mg/0.8mL Pen	☐ Induction Dose: Inject 160mg SC on day 1, then inject 80mg SC on day 15 ☐ Maintenance Dose: Inject 40mg SC once weekly ☐ Maintenance Dose: Inject 80mg SC every other week ☐ Other:_____	3	0
☐ OTEZLA	☐ Starter Pack ☐ 30mg Tablet	☐ Titration: Take 1 tablet by mouth at week 0 then increase as directed ☐ Take 30mg by mouth twice daily	55	0

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.