

# GASTROENTEROLOGY SPECIALTY A-O

## Prescription Referral Form



Phone: 843-352-7662 | Fax: 833-898-3992 | Backup Fax 843-352-7629 | 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

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 ALL CHART NOTES AND LABWORK

Diagnosis: \_\_\_\_\_ ICD 10:  K50.9 (CROHNS)  K51.90 (UC)  \_\_\_\_\_  
 Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Tb Test Results: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Latex Allergy:  Yes  No  
 Previous / Failed Medications: \_\_\_\_\_

### PRESCRIBING INFORMATION

NEW  RESTART  CONTINUING | SHIPPING PREFERENCE:  Deliver Medication to Patient  Deliver Medication to MDO for First Fill

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> <b>CIMZIA</b>	<input type="checkbox"/> Cimzia Starter Kit	<input type="checkbox"/> <u>Induction Dose:</u> Inject 400mg SC at weeks 0, 2, and 4	6	0
	<input type="checkbox"/> 200mg PFS (2 x 200)	<input type="checkbox"/> <u>Maintenance Dose:</u> Inject 400mg SC every 4 weeks		
	<input type="checkbox"/> 200 LYO Powder (2 x 200)			
<input type="checkbox"/> <b>DUPIXENT</b>	<input type="checkbox"/> 300mg/2mL Pen	<input type="checkbox"/> Inject 300mg SC once weekly		
	<input type="checkbox"/> 300mg/2mL PFS			
<input type="checkbox"/> <b>ENTYVIO</b>	<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	3	0
	<input type="checkbox"/> 108mg/0.68mL PFS	<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	1	
	<input type="checkbox"/> 108mg/0.68mL Pen	<input type="checkbox"/> <u>Maintenance Dose:</u> Inject 108mg SC every 2 weeks (starting at week 6)		
<input type="checkbox"/> <b>HUMIRA</b> Citrate Free	<input type="checkbox"/> Crohns/UC Starter (80mg/0.8mL Pen)	<input type="checkbox"/> Inject 160mg SC on day 1, then inject 80mg SC on day 15	3	0
	<input type="checkbox"/> 40mg/0.4mL Pen	<input type="checkbox"/> Inject 80mg SC on day 1, then inject 80mg SC on day 2, then inject 80mg SC on day 15	3	0
	<input type="checkbox"/> 40mg/0.4mL PFS	<input type="checkbox"/> Inject 40mg SC every other week		
	<input type="checkbox"/> 80mg/0.8mL Pen	<input type="checkbox"/> Inject 40mg SC once weekly <input type="checkbox"/> Inject 80mg SC every other week		
<input type="checkbox"/> <b>OMVOH</b>	<input type="checkbox"/> 300mg/15mL Vial	<input type="checkbox"/> <u>Induction Dose:</u> Infuse 300mg via IV over 30 minutes at weeks 0, 4, and 8		
	<input type="checkbox"/> 100mg/mL Pen	<input type="checkbox"/> <u>Maintenance Dose:</u> Inject 200mg SC at week 12 and inject 200mg SC every 4 weeks thereafter		

### 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 payer