NEUROLOGY P-Z
Prescription Referral Form

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

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: Multiple Sclerosis ICD 10: ☐G35 ☐ Other: ______ Weight: ______ Height: ______ Tb Test Results: ______

☐Relapsing Remitting ☐Primary Progressive ☐Secondary Progressive ☐Progressive Relapsing

Drug Allergies: ______ Previous / Failed Medications: ______

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver Medication to Patient ☐ Deliver Medication to MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ PLEGRIDY	☐ Starter Pack (Pen) 63mcg/0.5mL/94mcg/0.5mL ☐ Starter Pack (PFS) 63mcg/0.5mL/94mcg/0.5mL ☐ 125mcg/0.5mL PFS ☐ 125mcg/0.5mL Pen	☐ Induction Dose: Inject 63mcg SC on day 1, then inject 94mcg SC on day 15, then inject 125mcg SC on day 29		
		☐ Maintenance Dose: Inject 125mcg SC every 14 days		
		☐ Induction Dose: Inject 63mcg IM on day 1, then inject 94mcg IM on day 15, then inject 125mcg IM on day 29		
		☐ Maintenance Dose: Inject 125mcg IM every 14 days		
☐ REBIF	☐ Titration Pack (PFS) ☐ Titration Pack (Rebidose) ☐ 22mcg/0.5mL PFS ☐ 44mcg/0.5mL PFS ☐ 44mcg/0.5mL (Rebidose)	☐ Induction Dose: GOAL DOSE 22mcg Weeks 1 -2: Inject 4.4mcg SC three times weekly Weeks 3-4: Inject 11mcg SC three times weekly Weeks 5+: Inject 22mcg SC three times weekly		
		☐ Maintenance Dose: Inject 22mcg SC three times weekly		
		☐ Induction Dose: GOAL DOSE 44mcg Weeks 1 -2: Inject 8.8mcg SC three times weekly Weeks 3-4: Inject 22mcg SC three times weekly Weeks 5+: Inject 44mcg SC three times weekly		
		☐ Maintenance Dose: Inject 44mcg SC three times weekly		
		☐ Other: ______		
☐ DIMETHYL FUMARATE	☐ Starter Pack ☐ 120mg Capsules ☐ 240mg Capsules	☐ Induction Dose: Take 120mg by mouth twice daily for 7 days		
		☐ Maintenance Dose: Take 240mg by mouth twice daily		
☐ TYSABRI	☐ 300mg/mL Vial	☐ Infuse 300mg via IV over one hour every 4 weeks		
☐ ZEPOSIA	☐ Titration Starter Kit ☐ 0.92mg Capsule	☐ Titration: Take 0.23mg by mouth days 1-4, then 0.46mg days 5-7, then 0.92mg thereafter	7	
		☐ Maintenance Dose: Take 0.92mg by mouth once 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 payer

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.