DERMATOLOGY A-O
Prescription Referral Form

blue sky SPECIALTY PHARMACY

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: _____ 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 MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ **ADBRY**	☐ 150mg/mL PFS	☐ Induction Dose: Inject 600mg SC on Day 1 ☐ Maintenance Dose: Inject 300mg SC every _____ weeks	4	0
☐ **BIMZELX**	☐ 160mg/mL PFS ☐ 160mg/mL Pen	☐ Induction Dose: Inject 320mg SC on weeks 0, 4, 8, 12, and 16 ☐ Maintenance Dose (<120kg): Inject 320mg SC every 8 weeks ☐ Maintenance Dose (≥120kg): Inject 320mg SC every 4 weeks	10	0
☐ **CIBINQO**	☐ 50mg Tab ☐ 100mg Tab ☐ 200mg Tab	☐ 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, week 2, and week 4 ☐ Maintenance Dose: Inject _____ mg SC every other week	3	0
☐ **COSENTYX**	☐ 150mg/mL PFS ☐ 300mg/mL PFS ☐ 150mg/mL SensoReady ☐ 300mg/mL UnoReady	☐ Induction Dose: Inject 300mg SC on weeks 0, 1, 2, 3, and 4 ☐ Maintenance Dose: Inject 300mg SC every 4 weeks ☐ Maintenance Dose: Inject 300mg SC every 2 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
☐ **ENBREL**	☐ 50mg/mL PFS ☐ 50mg/mL SureClick ☐ 50mg Mini	☐ Induction Dose: (Psoriasis) Inject 50mg SC twice weekly for 12 weeks ☐ Maintenance Dose: Inject 50mg SC once weekly	8	2
☐ **HUMIRA**	☐ Psoriasis Starter Kit Pen ☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL Pen	☐ 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
	☐ HS Starter Kit Pen ☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL Pen ☐ 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
☐ **ILUMYA**	☐ 100mg/mL PFS	☐ Induction Dose: Inject 100mg SC at week 0 and week 4 ☐ Maintenance Dose: Inject 100mg SC every 12 weeks	2	0
☐ **OLUMIANT**	☐ 2mg Tablet ☐ 4mg Tablet	☐ Take 2mg by mouth once daily ☐ Take 4mg by mouth once daily		
☐ **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 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.