

DERMATOLOGY A-O

Prescription Referral Form



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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
<input type="checkbox"/> ADBRY	<input type="checkbox"/> 150mg/mL PFS	<input type="checkbox"/> <u>Induction Dose</u> : Inject 600mg SC on Day 1 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 300mg SC every _____ weeks	4	0
<input type="checkbox"/> BIMZELX	<input type="checkbox"/> 160mg/mL PFS <input type="checkbox"/> 160mg/mL Pen	<input type="checkbox"/> <u>Induction Dose</u> : Inject 320mg SC on weeks 0, 4, 8, 12, and 16 <input type="checkbox"/> <u>Maintenance Dose</u> (<120kg): Inject 320mg SC every 8 weeks <input type="checkbox"/> <u>Maintenance Dose</u> (>120kg): Inject 320mg SC every 4 weeks	10	0
<input type="checkbox"/> CIBINQO	<input type="checkbox"/> 50mg Tab <input type="checkbox"/> 100mg Tab <input type="checkbox"/> 200mg Tab	<input type="checkbox"/> Take _____mg by mouth once daily		
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> 200mg/mL Starter Kit Weight: _____ <input type="checkbox"/> 200mg/mL PFS	<input type="checkbox"/> <u>Induction Dose</u> : (if <90kg) Inject 400mg SC on week 0, week 2, and week 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject _____ mg SC every other week	3	0
<input type="checkbox"/> COSENTYX	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 300mg/mL PFS <input type="checkbox"/> 150mg/mL SensoReady <input type="checkbox"/> 300mg/mL UnoReady	<input type="checkbox"/> <u>Induction Dose</u> : Inject 300mg SC on weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 300mg SC every 4 weeks <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 300mg SC every 2 weeks	10	0
<input type="checkbox"/> DUPIXENT	<input type="checkbox"/> 300mg/2mL PFS <input type="checkbox"/> 300mg/2mL Pen	<input type="checkbox"/> <u>Induction Dose</u> : Inject 600mg SC on day 1 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 300mg SC every 2 weeks thereafter	4	0
<input type="checkbox"/> ENBREL	<input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 50mg/mL SureClick <input type="checkbox"/> 50mg Mini	<input type="checkbox"/> <u>Induction Dose</u> : (Psoriasis) Inject 50mg SC twice weekly for 12 weeks <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 50mg SC once weekly	8	2
<input type="checkbox"/> HUMIRA	<input type="checkbox"/> Psoriasis Starter Kit Pen <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> HS Starter Kit Pen <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 80mg/0.8mL Pen	<input type="checkbox"/> <u>Induction Dose</u> : Inject 80mg SC on day 1, then inject 40mg SC on day 8, and inject 40mg SC on day 22 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 40mg SC every 2 weeks <input type="checkbox"/> Other: _____	3	0
		<input type="checkbox"/> <u>Induction Dose</u> : Inject 160mg SC on day 1, then inject 80mg SC on day 15 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 40mg SC once weekly <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 80mg SC every other week <input type="checkbox"/> Other: _____	3	0
<input type="checkbox"/> ILUMYA	<input type="checkbox"/> 100mg/mL PFS	<input type="checkbox"/> <u>Induction Dose</u> : Inject 100mg SC at week 0 and week 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 100mg SC every 12 weeks	2	0
<input type="checkbox"/> OLUMIANT	<input type="checkbox"/> 2mg Tablet <input type="checkbox"/> 4mg Tablet	<input type="checkbox"/> Take 2mg by mouth once daily		
		<input type="checkbox"/> Take 4mg by mouth once daily		
<input type="checkbox"/> OTEZLA	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> <u>Titration</u> : Take 1 tablet by mouth at week 0, then increase as directed	55	0
		<input type="checkbox"/> Take 30mg by mouth twice daily		

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

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