Dermatology Prescription Referral Form

P–Z

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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

Prescriber Name: ____________________________ DEA: ______________________ NPI: _______________________________

Address: ____

Phone Number: _________________________ Fax Number: ______________________ Contact Person: ___________________

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	REFILLS
☐ REMICADE	☐ 100mg Vial	☐ Infuse ______mg/kg intravenously at weeks 0, week 2, and week 6		
	Weight: _______	☐ Infuse ______mg/kg intravenously every _______ weeks		
☐ SILIQ	☐ 210mg/1.5mL PFS	☐ Induction Dose: Inject 210mg SC at weeks 0, 1, and 2	3	0
		☐ Maintenance Dose: Inject 210mg SC every 2 weeks		
☐ SIMPONI	☐ 50mg Pen ☐ 50mg PFS	☐ Inject 50mg SC once monthly		
☐ SKYRIZI	☐ 150mg/mL PFS	☐ Induction Dose: Inject 150mg SC at weeks 0 and 4	2	0
	☐ 150mg/mL Pen	☐ Maintenance Dose: Inject 150mg SC every 12 weeks		
☐ STELARA	☐ 45mg/0.5mL PFS	☐ Induction Dose: Inject 45mg SC on week 0 and week 4	1	0
	☐ 90mg/mL PFS	☐ Maintenance Dose: Inject 45mg SC every 12 weeks		
		☐ Induction Dose: Inject 90mg SC on week 0 and week 4	2	0
	Weight: __________	☐ Maintenance Dose: Inject 90mg SC every 12 weeks		
☐ TALTZ	☐ 80mg/mL Autoinjector	☐ Initial Dose: Inject 160mg SC at week 0 and inject 80mg SC at week 2	3	0
	☐ 80mg/mL PFS	☐ Induction Dose: Inject 80mg SC every 2 weeks (weeks 4-10)	2	1
		☐ Maintenance Dose: Inject 80mg SC every 4 weeks(starting week 12)		
☐ TREMFYA	☐ 100mg/mL Pen	☐ Induction Dose: Inject 100mg SC at week 0 and week 4	2	0
	☐ 100mg/mL PFS	☐ Maintenance Dose: Inject 100mg SC every 8 weeks		
☐ _________	☐ ___________________	☐ ____		
☐ _________	☐ ___________________	☐ ____		

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.

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