Gastroenterology – Non Specialty
Prescription Referral Form

Phone: 843.352.7662 | Fax 833.898.3992 | Backup Fax 843.352.7632 | 1501 Belle Isle Ave #150 Mt. Pleasant SC 29464

PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ SSN: _____ **(PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS)**

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____ Contact Person: _____

PATIENT CLINICAL INFORMATION / HISTORY

Diagnosis: _____ ICD 10: _____ Weight:_____ Height: _____ Drug Allergies:_____

Previous / Failed Medications:_____

Notes:_____

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver medication to patient ☐ Deliver medication to MD

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ ALINIA	☐ 500mg Tablet	☐ Take 1 tablet by mouth twice daily		
☐ CREON	☐ _____ Lipase Units	☐ Take _____ capsules during each meal and _____ during each snack		
☐ DIFICID	☐ 200mg Tablet	☐ Take 200mg by mouth twice daily	20	0
☐ TALICIA	☐ 10mg/250mg/12.5mg Capsules	☐ Take 4 capsules by mouth three times a day for 14 days	168	
☐ VEMLIDY	☐ 25mg Tablet	☐ Take 1 tablet by mouth once daily		
☐ XIFAXAN	☐ 550mg Tablet	☐ Irritable Bowel Syndrome; Take 1 tablet by mouth three times a day ☐ Hepatic Encephalopathy; Take 1 tablet by mouth twice daily	42	
☐ _____	☐ _____	☐ _____		
☐ _____	☐ _____	☐ _____		

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.