

Rheumatology & Endocrinology Prescription Referral Form

A-O



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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: _____ Tb Test Results: _____
 Previous / Failed Medications: _____
 Drug Allergies: _____ (PLEASE FORWARD CHART NOTES AND RELEVANT LABS)

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	REFILLS
<input type="checkbox"/> ACTEMRA	<input type="checkbox"/> 162mg PFS <input type="checkbox"/> 162mg ActPen <input type="checkbox"/> _____ Vial	<input type="checkbox"/> Inject 162mg SC once weekly <input type="checkbox"/> Inject 162mg SC every other week.		
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200 (x2) LVO Powder	<input type="checkbox"/> <u>Induction Dose</u> : Inject 400mg SC at week 0, at week 2, and at week 4 <input type="checkbox"/> Inject _____ mg SC once every _____ weeks		
<input type="checkbox"/> COSENTYX	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 150mg/mL Sensoready Pen	<input type="checkbox"/> <u>Induction Dose</u> : Inject _____ mg SC at weeks 0,1,2,3, and 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject _____ mg SC every 4 weeks		0
<input type="checkbox"/> ENBREL	<input type="checkbox"/> 50mg/mL Mini <input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 50mg/mL SureClick	<input type="checkbox"/> Inject 50mg SC once weekly <input type="checkbox"/> Inject _____mg SC _____ a week		
<input type="checkbox"/> HUMIRA (Citrate Free)	<input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 80mg/0.8mL Pen <input type="checkbox"/> 80mg/0.8mL PFS	<input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Inject 40mg SC once weekly <input type="checkbox"/> Inject 80mg SC every other week		
<input type="checkbox"/> KEVZARA	<input type="checkbox"/> 150mg PFS <input type="checkbox"/> 150mg Pen <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200mg Pen	<input type="checkbox"/> Inject 150mg SC every 2 weeks <input type="checkbox"/> Inject 200mg SC every 2 weeks		
<input type="checkbox"/> OLUMIANT	<input type="checkbox"/> 2mg Tablet	<input type="checkbox"/> Take 2mg by mouth once daily		
<input type="checkbox"/> ORENCIA	<input type="checkbox"/> 125mg/mL PFS <input type="checkbox"/> 125mg/mL Clickject	<input type="checkbox"/> Inject 125mg SC once weekly		
	<input type="checkbox"/> 250mg Vial Weight: _____	<input type="checkbox"/> <u>Induction Dose</u> : Infuse _____mg via IV at week 0, 2, and week 4. <input type="checkbox"/> <u>Maintenance Dose</u> : Infuse _____mg via IV every 4 weeks		
<input type="checkbox"/> OTEZLA	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> <u>Induction Dose</u> : Take 1 tablet by mouth on day 1, then increase as directed <input type="checkbox"/> Take 30mg by mouth twice daily	55	0
<input type="checkbox"/> OTREXUP	<input type="checkbox"/> 10mg <input type="checkbox"/> 12.5mg <input type="checkbox"/> 15mg <input type="checkbox"/> 17.5mg <input type="checkbox"/> 20mg <input type="checkbox"/> 22.5mg <input type="checkbox"/> 25mg	<input type="checkbox"/> Inject _____mg SC once weekly		

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.