GASTROENTEROLOGY SPECIALTY P-Z
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: ☐K50.9 (CROHNS) ☐K51.90 (UC) ☐ _____

Weight: _____ Height: _____ Tb Test Results: _____ Date Completed: _____ Latex Allergy: ☐Yes ☐No

Previous / Failed Medications: _____

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver Medication to Patient ☐ Deliver Medication to MDO for First Fill

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ REMICADE Weight: _____	☐ 100mg Vial	☐ Induction Dose: Infuse _____mg/kg via IV at week 0, week 2, and week 6 ☐ Maintenance Dose: Infuse _____mg/kg via IV every 8 weeks		
☐ RINVOQ	☐ 15mg Tablet ☐ 30mg Tablet ☐ 45mg Tablet	☐ Induction Dose: Take 45mg by mouth once daily for 8 weeks ☐ Induction Dose: Take 45mg by mouth once daily for 12 weeks ☐ Maintenance Dose: Take _____mg by mouth once daily		
☐ SIMPONI	☐ 100mg Smartject ☐ 100mg PFS	☐ Induction Dose: Inject 200mg SC at week 0, the inject 100mg SC at week 2 ☐ Maintenance Dose: Inject 100mg SC once every 4 weeks	4	0
☐ SKYRIZI	☐ 600mg Vial ☐ 180mg/1.2mL PFC ☐ 360mg/2.4mL PFC	☐ Induction Dose: Infuse 600mg via IV over 1 hour at week 0, week 4, and week 8 ☐ Maintenance Dose: Inject 180mg SC at week 12 and every 8 weeks thereafter ☐ Maintenance Dose: Inject 360mg SC at week 12 and every 8 weeks thereafter	3	0
☐ STELARA	☐ 130mg/26mL Vial ☐ 90mg/mL PFS	☐ Infuse _____mg via IV as a single dose over 60 minutes ☐ Inject 90mg SC 8 weeks after the initial IV dose, then every 8 weeks thereafter		
☐ VELSIPITY	☐ 2mg Tablet	☐ Take 2mg by mouth once daily		
☐ XELJANZ / XR	☐ 10mg Tablet ☐ 5mg Tablet ☐ 22mg Tablet ☐ 11mg Tablet	☐ Induction Dose: Take 10mg by mouth twice daily for _____ week(s) ☐ Maintenance Dose: Take 5mg by mouth twice daily ☐ Induction Dose: Take 22mg by mouth once daily for _____ week(s) ☐ Maintenance Dose: Take 11mg by mouth once daily		
☐ ZEPOSIA	☐ Starter Pack ☐ 0.92mg Capsule	☐ Titration: Take 0.23mg by mouth on week 0 and advance as directed ☐ Maintenance Dose: Take 0.92mg by mouth once daily	7	

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