Gastroenterology – 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: ☐ K50.9 (Crohns) ☐ K51.90 (UC) ☐ ______________________________________

Weight: __________ Height: _________ Tb Test Results: ________________ Date Completed: _____________ Latex Allergy ☐Yes ☐No

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 for first fill

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ CIMZIA	☐ Cimzia Starter Kit	☐ Induction Dose: Inject 400mg SC at weeks 0, 2, and 4	6	0
	☐ 200mg PFS (2 x 200)	☐ Maintenance Dose: Inject 400mg SC every 4 weeks		
	☐ 200 LYO Powder (2 x 200)			
☐ ENTYVIO	☐ 300mg Vial	☐ Induction Dose: Infuse 300mg via IV over 30 minutes at weeks 0, 2, and 6	3	0
		☐ Maintenance Dose: Infuse 300mg via IV over 30 minutes 8 weeks after 3 induction doses and continue every 8 weeks	1	
☐ HUMIRA (Citrate Free)	☐ Crohns/UC Starter (80mg/0.8mL Pen)	☐ Inject 160mg SC on day 1, then inject 80mg SC on day 15	3	0
		☐ Inject 80mg SC on day 1, then inject 80mg SC day on day 2, then inject 80mg SC on day 15	3	0
	☐ 40mg/0.4mL Pen	☐ Inject 40mg SC every other week		
	☐ 40mg/0.4mL PFS	☐ Inject 40mg SC once weekly		
	☐ 80mg/0.8mL Pen	☐ Inject 80mg SC every other week		
	☐ 80mg/0.8mL PFS			
☐ REMICADE	☐ 100mg Vial	☐ Induction Dose: Infuse _________mg/kg via IV at week 0, week 2, and week 6		
	Weight: _______	☐ Maintenance Dose: Infuse _________mg/kg via IV every 8 weeks		
☐ SIMPONI	☐ 100mg Smartject	☐ Induction Dose: Inject 200mg SC at week 0, then inject 100mg SC at week 2	4	0
	☐ 100mg PFS	☐ Maintenance Dose: Inject 100mg SC once every 4 weeks		
☐ STELARA	☐ 130mg/26mL Vial	☐ Infuse _______mg via IV as a single dose over 60 minutes		
	☐ 90mg/mL PFS	☐ Inject 90mg SC 8 weeks after initial IV dose, then every 8 weeks thereafter		
☐ XELJANZ/XR	☐ 10mg Tablet	☐ Induction Dose: Take 10mg by mouth twice daily for _______ week(s)		
	☐ 5mg Tablet	☐ Maintenance Dose: Take 5mg by mouth twice daily		
	☐ 22mg Tablet	☐ Induction Dose: Take 22mg by mouth once daily for _______ week(s)		
	☐ 11mg Tablet	☐ Maintenance Dose: Take 11mg by mouth once daily		
☐ __________	☐ ______________________	☐ ____		
☐ __________	☐ ______________________	☐ ____		

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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