

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: _____
 Office's Preferred Method of Contact: Phone Fax Portal Email: _____ Other: _____

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
<input type="checkbox"/> REMICADE	<input type="checkbox"/> 100mg Vial Weight: _____	<input type="checkbox"/> Infuse _____ mg/kg intravenously at weeks 0, week 2, and week 6 <input type="checkbox"/> Infuse _____ mg/kg intravenously every _____ weeks		
<input type="checkbox"/> RINVOQ	<input type="checkbox"/> 15mg ER Tablet	<input type="checkbox"/> Take 15mg by mouth once daily		
<input type="checkbox"/> SILIQ	<input type="checkbox"/> 210mg/1.5mL PFS	<input type="checkbox"/> <u>Induction Dose</u> : Inject 210mg SC at weeks 0, 1, and 2 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 210mg SC every 2 weeks	3	0
<input type="checkbox"/> SIMPONI	<input type="checkbox"/> 50mg Pen <input type="checkbox"/> 50mg PFS	<input type="checkbox"/> Inject 50mg SC once monthly		
<input type="checkbox"/> SKYRIZI	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 150mg/mL Pen	<input type="checkbox"/> <u>Induction Dose</u> : Inject 150mg SC at weeks 0 and 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 150mg SC every 12 weeks	2	0
<input type="checkbox"/> STELARA	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/mL PFS Weight: _____	<input type="checkbox"/> <u>Induction Dose</u> : Inject 45mg SC on week 0 and week 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 45mg SC every 12 weeks <input type="checkbox"/> <u>Induction Dose</u> : Inject 90mg SC on week 0 and week 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 90mg SC every 12 weeks	1 2	0 0
<input type="checkbox"/> TALTZ	<input type="checkbox"/> 80mg/mL Autoinjector <input type="checkbox"/> 80mg/mL PFS	<input type="checkbox"/> <u>Initial Dose</u> : Inject 160mg SC at week 0 and inject 80mg SC at week 2 <input type="checkbox"/> <u>Induction Dose</u> : Inject 80mg SC every 2 weeks (weeks 4-10) <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 80mg SC every 4 weeks (starting week 12)	3 2	0 1
<input type="checkbox"/> TREMFYA	<input type="checkbox"/> 100mg/mL Pen <input type="checkbox"/> 100mg/mL PFS	<input type="checkbox"/> <u>Induction Dose</u> : Inject 100mg SC at week 0 and week 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 100mg SC every 8 weeks	2	0
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I authorize Blue Sky Specialty Pharmacy and its 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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