Gastroenterology – Specialty
Prescription Referral Form

blue sky SPECIALTY PHARMACY

Phone: 843.352.7662 | Fax 833.898.3992 | Backup Fax 843.352.7632 | 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

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: ☐ K50.9 (Crohns) ☐ K51.90 (UC) ☐ _____

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

Previous / Failed Medications:_____ Drug Allergies: _____

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 ☐ 200mg PFS (2 x 200) ☐ 200 LYO Powder (2 x 200)	☐ Induction Dose: Inject 400mg SC at weeks 0, 2, and 4 ☐ Maintenance Dose: Inject 400mg SC every 4 weeks	6	0
☐ ENTYVIO	☐ 300mg Vial	☐ Induction Dose: Infuse 300mg via IV over 30 minutes at weeks 0, 2, and 6 ☐ Maintenance Dose: Infuse 300mg via IV over 30 minutes 8 weeks after 3 induction doses and continue every 8 weeks	3 1	0
☐ HUMIRA (Citrate Free)	☐ Crohns/UC Starter (80mg/0.8mL Pen)	☐ Inject 160mg SC on day 1, then inject 80mg SC on day 15 ☐ Inject 80mg SC on day 1, then inject 80mg SC day on day 2, then inject 80mg SC on day 15	3 3	0 0
	☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL PFS ☐ 80mg/0.8mL Pen ☐ 80mg/0.8mL PFS	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once weekly ☐ Inject 80mg SC every other week		
☐ REMICADE	☐ 100mg Vial Weight: _____	☐ 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		
☐ SIMPONI	☐ 100mg Smartject ☐ 100mg PFS	☐ Induction Dose: Inject 200mg SC at week 0, then inject 100mg SC at week 2 ☐ Maintenance Dose: Inject 100mg SC once every 4 weeks	4	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 initial IV dose, then every 8 weeks thereafter		
☐ XELJANZ/XR	☐ 10mg Tablet ☐ 5mg Tablet	☐ Induction Dose: Take 10mg by mouth twice daily for _____ week(s) ☐ Maintenance Dose: Take 5mg by mouth twice daily		
	☐ 22mg Tablet ☐ 11mg Tablet	☐ Induction Dose: Take 22mg by mouth once daily for _____ week(s) ☐ Maintenance Dose: Take 11mg by mouth once daily		
☐ ZEPOSIA	☐ Titration Pack ☐ 0.92mg Capsule	☐ Titration: Take 0.23mg by mouth days 1-4, then take 0.46mg by mouth days 5-7 ☐ Maintenance Dose: (Starting day 8) Take 0.92mg by mouth once daily	7	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 payor.