Rheumatology & Endocrinology Prescription Referral Form

P–Z

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: ___________________

PATIENT CLINICAL INFORMATION / HISTORY – PLEASE FORWARD CHART NOTES AND RELEVANT LABS

Diagnosis: ______________________ ICD 10: __________ Weight:_______ Height: _______ Tb Test Results: _______________

Previous / Failed Medications: ____

Drug Allergies: ____

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ RASUVO	☐_______ mg	☐ Inject _______mg SC once weekly		
☐ REMICADE	☐ 100mg Vial	☐ Infuse _______mg/kg intravenously at week 0, week 2, and week 6		
	Weight: _______	☐ Infuse _______mg/kg intravenously every _______ weeks		
☐ RINVOQ	☐ 15mg ER Tablet	☐ Take 15mg by mouth once daily		
☐ RITUXAN	☐ 500mg/50mL Vial	☐ Infuse 1,000mg intravenously on day 1 and day 15		
	Height: _______ Weight: _______	☐ Infuse 1,000mg intravenously every 24 weeks		
☐ SIMPONI	☐ 50mg/0.5mL SmartJect ☐ Aria	☐ Inject 50mg SC once monthly		
	☐ 50mg/0.5mL PFS	☐ Infuse _______mg via IV at weeks 0 and 4, then every 8 weeks thereafter		
☐ SKYRIZI	☐ 150mg/mL PFS	☐ Induction Dose: Inject 150mg SC at weeks 0 and 4	2	0
	☐ 150mg/mL Pen	☐ Maintenance Dose: Inject 150mg SC every 12 weeks		
☐ STELARA	☐ 45MG PFS ☐ 90MG PFS	☐ Inject 45mg SC on week 0 and week 4	1	0
		☐ Inject 90mg SC on week 0 and week 4	2	0
	Weight: _______	☐ Inject _________mg SC every 12 weeks		
☐ TALTZ	☐ 80mg Autoinjector	☐ Initial Dose: Inject 160mg SC on week 0	2	0
	☐ 80mg PFS	☐ Maintenance Dose: Inject 80mg SC once every 4 weeks		
		☐ Initial Dose: Inject 160mg SC on week 0 and inject 80mg SC at week 2	3	0
		☐ Induction Dose: Inject 80mg SC every 2 weeks (weeks 4-10)	2	1
		☐ Maintenance Dose: Inject 80mg SC every 4 weeks (starting at week 12)		
☐ TREMFYA	☐ 100mg/mL Pen	☐ Induction Dose: Inject 100mg SC at week 0 and week 4	2	0
	☐ 100mg/mL PFS	☐ Maintenance Dose: Inject 100mg SC every 8 weeks		
☐ XELJANZ	☐ 5mg Tablet	☐ Take 5mg by mouth twice daily		
☐ XELJANZ XR	☐ 11mg Tablet	☐ 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.

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.