

Gastroenterology - Specialty Prescription Referral Form



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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: _____

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