Isotretinoin
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

First Name: _____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ SSN: _____ iPledge ID: _____

Urine Pregnancy Test Date: _____ **(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: ☐ Acne Vulgaris ☐ Cystic Acne ☐ Other _____ ICD 10: ☐ L70.0 ☐ Other_____

Weight: _____ Total Cumulative Dose: _____/kg Total Cumulative Dose to Date: _____/kg

Topicals Failed: _____ Antibiotics Failed: _____

Drug Allergies: _____ **(PLEASE FORWARD CHART NOTES AND RELEVANT LABS)**

CAN THE PATIENT COMPLY WITH DIETARY RESTRICTIONS REQUIRED FOR GENERIC ISOTRETINOIN? ☐ YES ☐ NO

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ ABSORICA	☐ 10mg ☐ 20mg ☐ 30mg ☐ 40mg	☐ Take one capsule by mouth twice daily with or without food ☐ _____	60	0
☐ ISOTRETINOIN CLARAVIS MYORISAN AMNESTEEM ZENATANE	☐ 10mg ☐ 20mg ☐ 30mg ☐ 40mg	☐ Take one capsule by mouth once daily with food ☐ Take one capsule by mouth twice daily with food ☐ _____	30 60	0 0
☐ _____	☐ _____	☐ _____		
☐ _____	☐ _____	☐ _____		
☐ _____	☐ _____	☐ _____		
☐ _____	☐ _____	☐ _____		

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.