Basal Cell Carcinoma
Prescription Referral Form

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: _________
Cell Phone: __________________ SSN: _______________ **(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: Locally advanced basal cell carcinoma ICD 10: C44.91
Has patient's basal cell carcinoma recurred following surgery or radiation therapy? ☐Yes ☐No
Is the patient a candidate for surgery or radiation therapy? ☐Yes ☐No
Drug Allergies:____
Previous / Failed Medications: ____
____ **(PLEASE FORWARD ALL RELEVANT CHART NOTES)**

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ ERIVEDGE	☐ 150mg Capsule	☐ Take one capsule by mouth once daily		
☐ ODOMZO	☐ 200mg Capsule	☐ Take one capsule by mouth once daily on an empty Stomach at least 1 hour before or 2 hours after a meal		
☐ __________	☐ ______________	☐ ______________________________________		
☐ __________	☐ ______________	☐ ______________________________________		
☐ __________	☐ ______________	☐ ______________________________________		
☐ __________	☐ ______________	☐ ______________________________________		

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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