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 - 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

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 ALL CHART NOTES AND LABWORK

Diagnosis: ☐Acne Vulgaris ☐Cystic Acne ☐ _____ ICD 10: ☐L70.0 ☐ _____

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

Topicals Failed: _____ Antibiotics Failed: _____

Drug Allergies: _____

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 MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ ABSORICA	☐ 10mg ☐ 20mg ☐ 30mg ☐ 40mg	☐ Take 1 capsule by mouth twice daily with or without food ☐ _____	60	0
☐ ISOTRETINOIN CLARAVIS MYORISAN AMNESTEEM ZENATANE	☐ 10mg ☐ 20mg ☐ 30mg ☐ 40mg	☐ Take 1 capsule by mouth once daily with food ☐ Take 1 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 payer