DERMATOLOGY O-Z
Prescription Referral Form

Phone: 843-352-7662 | Fax: 833-898-3992 | Backup Fax 843-352-7629 | 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: ____________ ICD 10: ______ Weight: ______ Height: ______ Tb Test Results: ______

Drug Allergies: ____________ BSA%: ______ Previous / Failed Medications: ____________

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver Medication to Patient ☐ Deliver Medication to MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ OLUMIANT	☐ 2mg Tablet	☐ Take 2mg by mouth once daily		
	☐ 4mg Tablet	☐ Take 4mg by mouth once daily		
☐ OTEZLA	☐ Starter Pack	☐ Titration: Take 1 tablet by mouth at week 0, then increase as directed	55	0
	☐ 30mg Tablet	☐ Take 30mg by mouth twice daily		
☐ REMICADE	☐ 100mg Vial	☐ Infuse ______ mg/kg intravenously at weeks 0, week 2, and week 6		
Weight: ______		☐ Infuse ______ mg/kg intravenously every ______ weeks		
☐ RINVOQ	☐ 15mg ER Tablet	☐ Take 15mg by mouth once daily		
	☐ 30mg ER Tablet	☐ Take 30mg by mouth once daily		
☐ SILIQ	☐ 210mg/1.5mL PFS	☐ Induction Dose: Inject 210mg SC at weeks 0, 1, and 2	3	0
		☐ Maintenance Dose: Inject 210mg SC every 2 weeks		
☐ SIMPONI	☐ 50mg Pen ☐ 50mg PFS	☐ Inject 50mg SC once monthly		
☐ SKYRIZI	☐ 150mg/mL PFS	☐ Induction Dose: Inject 150mg SC at weeks 0 and week 4	2	0
	☐ 150mg/mL Pen	☐ Maintenance Dose: Inject 150mg SC every 12 weeks		
☐ SOTYKTU	☐ 6mg Tablet	☐ Take 6mg by mouth once daily with or without food		
☐ STELARA	☐ 45mg/0.5mL PFS	☐ Induction Dose: Inject 45mg SC on week 0 and week 4	1	0
	☐ 90mg/mL PFS	☐ Maintenance Dose: Inject 45mg SC every 12 weeks		
		☐ Induction Dose: Inject 90mg SC on week 0 and week 4	2	0
Weight: ______		☐ Maintenance Dose: Inject 90mg SC every 12 weeks		
☐ TALTZ	☐ 80mg/mL Autoinjector	☐ Initial Dose: Inject 160mg SC at week 0 and inject 80mg SC at week 2	3	0
	☐ 80mg/mL PFS	☐ Induction Dose: Inject 80mg SC every 2 weeks (weeks 4-10)	2	1
		☐ Maintenance Dose: Inject 80mg SC every 4 weeks (starting week 12)		
☐ TREMFYA	☐ 100mg/mL One-Press 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		
☐ XOLAIR	☐ 150mg/mL PFS	☐ Inject 150mg SC every 4 weeks		
	☐ 150mg Single Dose Vial	☐ Inject 300mg SC every 4 weeks		

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

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.