DERMATOLOGY A-N
Prescription Referral Form

blue sky SPECIALTY PHARMACY

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
☐ ADBRY	☐ 150mg/mL PFS ☐ 300mg/2mL Autoinjector	☐ Induction Dose: Inject 600mg SC on Day 1 ☐ Maintenance Dose: Inject 300mg SC every _____ weeks	4	0
☐ BIMZELX	☐ 160mg/mL PFS ☐ 160mg/mL Pen	☐ Induction Dose: Inject 320mg SC on weeks 0, 4, 8, 12, and 16 ☐ Induction Dose: Inject 320mg SC on weeks 0, 2, 4, 6, 8, 10, 12, 14 and 16 ☐ Maintenance Dose (<120kg): Inject 320mg SC every 8 weeks ☐ Maintenance Dose (≥120kg): Inject 320mg SC every 4 weeks ☐ Other: Inject _____ mg SC every _____ weeks	10 18	0 0
☐ CIBINQO	☐ 50mg Tab ☐ 100mg Tab ☐ 200mg Tab	☐ Take _____mg by mouth once daily		
☐ CIMZIA Weight: _____	☐ 200mg/mL Starter Kit ☐ 200mg/mL PFS	☐ Induction Dose: (if ≤90kg) Inject 400mg SC on week 0, week 2, and week 4 ☐ Maintenance Dose: Inject _____ mg SC every other week	3	0
☐ COSENTYX	☐ 150mg/mL PFS ☐ 300mg/mL PFS ☐ 150mg/mL SensoReady ☐ 300mg/mL UnoReady	☐ Induction Dose: Inject 300mg SC on weeks 0, 1, 2, 3, and 4 ☐ Maintenance Dose: Inject 300mg SC every 4 weeks ☐ Maintenance Dose: Inject 300mg SC every 2 weeks	10	0
☐ DUPIXENT	☐ 300mg/2mL PFS ☐ 300mg/2mL Pen	☐ Induction Dose: Inject 600mg SC on day 1 ☐ Maintenance Dose: Inject 300mg SC every 2 weeks thereafter	4	0
☐ EBGLYSS	☐ 250mg/mL PFS ☐ 250mg/mL Pen	☐ Induction Dose: Inject 500mg SC on week 0 and 2 then inject 250mg SC every 2 weeks until week 16 ☐ Maintenance Dose: Inject 250mg SC every 4 weeks	20mL	0
☐ ENBREL	☐ 50mg/mL PFS ☐ 50mg Mini ☐ 50mg/mL SureClick	☐ Induction Dose: (Psoriasis) Inject 50mg SC twice weekly for 12 weeks ☐ Maintenance Dose: Inject 50mg SC once weekly	8	2
☐ HUMIRA	☐ Psoriasis Starter Kit Pen ☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL Pen ☐ HS Starter Kit Pen ☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL Pen ☐ 80mg/0.8mL Pen	☐ Induction Dose: Inject 80mg SC on day 1, then inject 40mg SC on day 8, and inject 40mg SC on day 22 ☐ Maintenance Dose: Inject 40mg SC every 2 weeks ☐ Induction Dose: Inject 160mg SC on day 1, then inject 80mg SC on day 15 ☐ Maintenance Dose: Inject 40mg SC once weekly ☐ Maintenance Dose: Inject 80mg SC every other week ☐ Other: _____	3 3	0 0
☐ ILUMYA	☐ 100mg/mL PFS	☐ Induction Dose: Inject 100mg SC at week 0 and week 4 ☐ Maintenance Dose: Inject 100mg SC every 12 weeks	2	0
☐ NEMLUVIO Weight: _____	☐ 30mg Pen	☐ Induction Dose: Inject 60mg SC on day 1 ☐ Maintenance Dose (<90kg): Inject 30mg SC every 4 weeks ☐ Maintenance Dose (≥90kg): Inject 60mg SC every 4 weeks	2	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