Rheumatology – A-O
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

Prescriber 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 CHART NOTES AND RELEVANT LABS

Diagnosis: _____ ICD 10: _____ Weight:_____ Height: _____ Tb Test Results: _____

Drug Allergies: _____ Previous / Failed Medications: _____

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ ACTEMRA	☐ 162mg PFS ☐162mg ActPen ☐_____ Vial	☐ Inject 162mg SC once weekly ☐ Inject 162mg SC every other week.		
☐ CIMZIA	☐ Cimzia Starter Kit ☐ 200mg PFS ☐ 200 (x2) LVO Powder	☐ Induction Dose: Inject 400mg SC at week 0, at week 2, and at week 4 ☐ Inject _____ mg SC once every _____ weeks		
☐ COSENTYX	☐ 150mg/mL PFS ☐ 150mg/mL Sensoready Pen	☐ Induction Dose: Inject _____ mg SC at weeks 0,1,2,3, and 4 ☐ Maintenance Dose: Inject _____mg SC every 4 weeks		0
☐ ENBREL	☐ 50mg/mL Mini ☐ 50mg/mL PFS ☐ 50mg/mL SureClick	☐ Inject 50mg SC once weekly ☐ Inject _____mg SC _____ a week		
☐ HUMIRA (Citrate Free)	☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL PFS	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once weekly		
	☐ 80mg/0.8mL Pen	☐ Inject 80mg SC every other week		
☐ KEVZARA	☐ 150mg PFS ☐ 150mg Pen ☐ 200mg PFS ☐ 200mg Pen	☐ Inject 150mg SC every 2 weeks ☐ Inject 200mg SC every 2 weeks		
☐ KRYSTEXXA	☐ 8mg/mL Vial Weight: _____	☐ Infuse _____mg intravenously every 2 weeks		
☐ OLUMIANT	☐ 2mg Tablet	☐ Take 2mg by mouth once daily		
☐ ORENCIA	☐ 125mg/mL PFS ☐ 125mg/mL Clickject	☐ Inject 125mg SC once weekly		
	☐ 250mg Vial Weight: _____	☐ Induction Dose: Infuse _____mg via IV at week 0, 2, and week 4. ☐ Maintenance Dose: Infuse _____mg via IV every 4 weeks		
☐ OTEZLA	☐ Starter Pack ☐ 30mg Tablets	☐ Induction Dose: Take 1 tablet by mouth on day 1, then increase as directed ☐ Take 30mg by mouth twice daily	55	0
☐ OTREXUP	☐ _____ mg	☐ Inject _____mg SC once weekly		

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.