

Isotretinoin Prescription Referral Form



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PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: _____ Last Name: _____ Date of Birth: _____ M F
 Street Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ SSN: _____ iPledge ID: _____
 Urine Pregnancy Test Date: _____ Patient Preferred Language: English Spanish _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
 Address: _____
 Phone Number: _____ Fax Number: _____ Contact Person: _____

PATIENT CLINICAL INFORMATION / HISTORY - PLEASE FORWARD CHART NOTES AND RELEVANT LABS

Diagnosis: Acne Vulgaris Cystic Acne Other _____ ICD 10: L70.0 Other _____
 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 MD

MEDICATION	DOSAGE	SIG	QTY	REFILLS
<input type="checkbox"/> ABSORICA	<input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Take one capsule by mouth twice daily with or without food <input type="checkbox"/> _____	60	0
<input type="checkbox"/> ISOTRETINOIN	<input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Take one capsule by mouth once daily with food <input type="checkbox"/> Take one capsule by mouth twice daily with food <input type="checkbox"/> _____	30 60	0 0
CLARAVIS MYORISAN AMNESTEEM ZENATANE				
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

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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