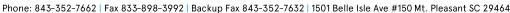
Creon

Prescription Referral Form





PATIENT INFORMATION - PLEASE FORWAR	D FRONT AND BACK OF INSURANCE CARDS			
First Name:	Last Name:	Date of Birth:		_
Street Address:	City:	State:	Zip:	
Cell Phone:SS	N: Patient Preferred Langu	age: 🗌 English 🗌 Spanish 🛭]	
PRESCRIBER INFORMATION				
Prescriber Name:	DEA:	NPI:		
Address:				
	Fax Number:	Contact Person:		
	one 🗆 Fax 🗆 Portal 🗆 Email:			
PATIENT CLINICAL INFORMATION / HISTOI				
(PLEASE AT	TACH COPY OF MOST RECENT CHART NOTES, PA	THOLOGY, AND LABS)		
Patient Weight	MINIMUM per-meal dose	MAXIMUM per	-meal dos	se
110lb (49.9kg)	36,000 Lipase Units	108,0	108,000 Lipase Units	
130lb (59.0kg)	36,000 Lipase Units		144,000 Lipase Units	
160lb (72.6kg)	72,000 Lipase Units	180,0	180,000 Lipase Units	
200lb (90.7kg)	72,000 Lipase Units	216,0	216,000 Lipase Units	
230lb (104.3kg)	72,000 Lipase Units	252,0	252,000 Lipase Units	
Other Notes:		L		
<u></u>				
PRESCRIBING INFORMATION				
STRENGTH	SIG		QTY	REFILLS
36,000 Lipase Units				
24,000 Lipase Units	Take capsules during	g each meal		
	Taka aanaulaa duwina			
☐ 12,000 Lipase Units	Take capsules during	g each snack		
,	Take during every meal and snack			
□ 4 000 · · · · · · ·	σ σ σ σ σ σ σ σ σ σ σ σ σ σ σ σ σ σ σ			
☐ 6,000 Lipase Units				
3,000 Lipase Units				
			1	
PRESCRIPTION SIGNATURE				

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.