Basal Cell Carcinoma
Prescription Referral Form

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: Locally advanced basal cell carcinoma ICD 10: C44.91

Has patient's basal cell carcinoma recurred following surgery or radiation therapy? ☐Yes ☐No

Is the patient a candidate for surgery or radiation therapy? ☐Yes ☐No

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
☐ ERIVEDGE	☐ 150mg Capsule	☐ Take one capsule by mouth once daily		
☐ ODOMZO	☐ 200mg Capsule	☐ Take one capsule by mouth once daily on an empty Stomach at least 1 hour before or 2 hours after a meal		

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.