GASTROENTEROLOGY SPECIALTY A-O
Prescription Referral Form

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: ☐K50.9 (CROHNS) ☐K51.90 (UC) ☐ __________

Weight: _________ Height: _______ Tb Test Results: ___________ Date Completed: ___________ Latex Allergy: ☐Yes ☐No

Previous / Failed Medications: ____

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver Medication to Patient ☐ Deliver Medication to MDO for First Fill

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ **CIMZIA**	☐ Cimzia Starter Kit ☐ 200mg PFS (2 x 200) ☐ 200 LYO Powder (2 x 200)	☐ <u>Induction Dose</u>: Inject 400mg SC at weeks 0, 2, and 4	6	0
		☐ <u>Maintenance Dose</u>: Inject 400mg SC every 4 weeks		
☐ **DUPIXENT**	☐ 300mg/2mL Pen ☐ 300mg/2mL PFS	☐ Inject 300mg SC once weekly		
☐ **ENTYVIO**	☐ 300mg Vial ☐ 108mg/0.68mL PFS ☐ 108mg/0.68mL Pen	☐ <u>Induction Dose</u>: Infuse 300mg via IV over 30 minutes at weeks 0, 2, and 6	3	0
		☐ <u>Maintenance Dose</u>: Infuse 300mg via IV over 30 minutes 8 weeks after 3 induction doses and continue every 8 weeks	1	
		☐ <u>Induction Dose</u>: Infuse 300mg via IV over 30 minutes at week 0 and 2	2	0
		☐ <u>Maintenance Dose</u>: Inject 108mg SC every 2 weeks (starting at week 6)		
☐ **HUMIRA** Citrate Free	☐ Crohns/UC Starter (80mg/0.8mL Pen) ☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL PFS ☐ 80mg/0.8mL Pen	☐ Inject 160mg SC on day 1, then inject 80mg SC on day 15	3	0
		☐ Inject 80mg SC on day 1, then inject 80mg SC on day 2, then inject 80mg SC on day 15	3	0
		☐ Inject 40mg SC every other week ☐ Inject 40mg SC once weekly ☐ Inject 80mg SC every other week		
☐ **OMVOH**	☐ 300mg/15mL Vial ☐ 100mg/mL Pen	☐ <u>Induction Dose</u>: Infuse 300mg via IV over 30 minutes at weeks 0, 4, and 8		
		☐ <u>Maintenance Dose</u>: Inject 200mg SC at week 12 and inject 200mg SC every 4 weeks thereafter		

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

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.