

GASTROENTEROLOGY SPECIALTY P-Z

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

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
<input type="checkbox"/> REMICADE Weight: _____	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> <u>Induction Dose</u> : Infuse _____mg/kg via IV at week 0, week 2, and week 6 <input type="checkbox"/> <u>Maintenance Dose</u> : Infuse _____mg/kg via IV every 8 weeks		
<input type="checkbox"/> RINVOQ	<input type="checkbox"/> 15mg Tablet <input type="checkbox"/> 30mg Tablet <input type="checkbox"/> 45mg Tablet	<input type="checkbox"/> <u>Induction Dose</u> : Take 45mg by mouth once daily for 8 weeks <input type="checkbox"/> <u>Induction Dose</u> : Take 45mg by mouth once daily for 12 weeks <input type="checkbox"/> <u>Maintenance Dose</u> : Take _____mg by mouth once daily		
<input type="checkbox"/> SIMPONI	<input type="checkbox"/> 100mg Smartject <input type="checkbox"/> 100mg PFS	<input type="checkbox"/> <u>Induction Dose</u> : Inject 200mg SC at week 0, the inject 100mg SC at week 2 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 100mg SC once every 4 weeks	4	0
<input type="checkbox"/> SKYRIZI	<input type="checkbox"/> 600mg Vial <input type="checkbox"/> 180mg/1.2mL PFC <input type="checkbox"/> 360mg/2.4mL PFC	<input type="checkbox"/> <u>Induction Dose</u> : Infuse 600mg via IV over 1 hour at week 0, week 4, and week 8 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 180mg SC at week 12 and every 8 weeks thereafter <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 360mg SC at week 12 and every 8 weeks thereafter	3	0
<input type="checkbox"/> STELARA	<input type="checkbox"/> 130mg/26mL Vial <input type="checkbox"/> 90mg/mL PFS	<input type="checkbox"/> Infuse _____mg via IV as a single dose over 60 minutes <input type="checkbox"/> Inject 90mg SC 8 weeks after the initial IV dose, then every 8 weeks thereafter		
<input type="checkbox"/> VELSIPITY	<input type="checkbox"/> 2mg Tablet	<input type="checkbox"/> Take 2mg by mouth once daily		
<input type="checkbox"/> XELJANZ / XR	<input type="checkbox"/> 10mg Tablet <input type="checkbox"/> 5mg Tablet <input type="checkbox"/> 22mg Tablet <input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> <u>Induction Dose</u> : Take 10mg by mouth twice daily for _____ week(s) <input type="checkbox"/> <u>Maintenance Dose</u> : Take 5mg by mouth twice daily		
		<input type="checkbox"/> <u>Induction Dose</u> : Take 22mg by mouth once daily for _____ week(s) <input type="checkbox"/> <u>Maintenance Dose</u> : Take 11mg by mouth once daily		
<input type="checkbox"/> ZEPOSIA	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 0.92mg Capsule	<input type="checkbox"/> <u>Titration</u> : Take 0.23mg by mouth on week 0 and advance as directed <input type="checkbox"/> <u>Maintenance Dose</u> : Take 0.92mg by mouth once daily	7	

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.