

RHEUMATOLOGY A-O

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: _____ Weight: _____ Height: _____ Tb Test Results: _____
 Drug Allergies: _____ Previous / Failed Medications: _____

PRESCRIBING INFORMATION

NEW RESTART CONTINUING | SHIPPING PREFERENCE: Deliver Medication to Patient Deliver Medication to MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> ACTEMRA	<input type="checkbox"/> 162mg PFS <input type="checkbox"/> 162mg ActPen <input type="checkbox"/> _____ Vial	<input type="checkbox"/> Inject 162mg SC once weekly <input type="checkbox"/> Inject 162mg SC every other week		
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200 (x2) LVO Powder	<input type="checkbox"/> Induction Dose: Inject 400mg SC at week 0, at week 2, and at week 4 <input type="checkbox"/> Inject _____mg SC once every _____ weeks		
<input type="checkbox"/> COSENTYX	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 150mg/mL Sensoready Pen	<input type="checkbox"/> Induction Dose: Inject _____mg SC at weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance Dose: Inject _____mg SC every 4 weeks	0	
<input type="checkbox"/> ENBREL	<input type="checkbox"/> 50mg/mL Mini <input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 50mg/mL SureClick	<input type="checkbox"/> Inject 50mg SC once weekly <input type="checkbox"/> Inject _____mg SC _____ a week		
<input type="checkbox"/> HUMIRA Citrate Free	<input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 80mg/0.8mL Pen	<input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Inject 40mg SC once weekly <input type="checkbox"/> Inject 80mg SC every other week		
<input type="checkbox"/> KEVZARA	<input type="checkbox"/> 150mg PFS <input type="checkbox"/> 150mg Pen <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200mg Pen	<input type="checkbox"/> Inject 150mg SC every 2 weeks <input type="checkbox"/> Inject 200mg SC every weeks		
<input type="checkbox"/> KRISTEXXA Weight: _____	<input type="checkbox"/> 8mg/mL Vial	<input type="checkbox"/> Infuse _____mg via IV every 2 weeks		
<input type="checkbox"/> OLUMIANT	<input type="checkbox"/> 2mg Tablet	<input type="checkbox"/> Take 2mg by mouth once daily		
<input type="checkbox"/> ORENCIA	<input type="checkbox"/> 125mg/mL PFS <input type="checkbox"/> 125mg/mL Clickject	<input type="checkbox"/> Inject 125mg SC once weekly		
	<input type="checkbox"/> 250mg Vial	<input type="checkbox"/> Induction Dose: Infuse _____mg via IV at week 0, 2, and week 4 <input type="checkbox"/> Maintenance Dose: Infuse _____mg via IV every 4 weeks		
<input type="checkbox"/> OTEZLA	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Induction Dose: Take 1 tablet by mouth on day 1, then increase as directed <input type="checkbox"/> Take 30mg by mouth twice daily	55	0
<input type="checkbox"/> OTREXUP	<input type="checkbox"/> _____mg	<input type="checkbox"/> Inject _____mg SC once weekly		

PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I authorize Blue Sky Specialty Pharmacy and its 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

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