Gastroenterology - Specialty
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: ____ ICD 10: ☐ K50.9 (Crohns) ☐ K51.90 (UC) ☐ _______

Weight: ________ Height: ________ Tb Test Results: ____________ Date Completed: ______________ Latex Allergy ☐Yes ☐No

Previous / Failed Medications:____ Drug Allergies: ________________________

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver medication to patient ☐ Deliver medication to MD for first fill

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ CIMZIA	☐ Cimzia Starter Kit ☐ 200mg PFS (2 x 200)	☐ Induction Dose: Inject 400mg SC at weeks 0, 2, and 4	6	0
	☐ 200 LYO Powder (2 x 200)	☐ Maintenance Dose: Inject 400mg SC every 4 weeks		
☐ DUPIXENT	☐ 300mg/2mL Pen ☐ 300mg/2mL PFS	☐ Inject 300mg SC once weekly		
☐ ENTYVIO	☐ 300mg Vial	☐ Induction Dose: Infuse 300mg via IV over 30 minutes at weeks 0, 2, and 6	3	0
		☐ Maintenance Dose: Infuse 300mg via IV over 30 minutes 8 weeks after 3 induction doses and continue every 8 weeks	1	
☐ HUMIRA (Citrate Free)	☐ Crohns/UC Starter (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
	☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL PFS	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once weekly		
	☐ 80mg/0.8mL Pen	☐ Inject 80mg SC every other week		
☐ REMICADE	☐ 100mg Vial	☐ Induction Dose: Infuse __________mg/kg via IV at week 0, week 2, and week 6		
	Weight: _______	☐ Maintenance Dose: Infuse __________mg/kg via IV every 8 weeks		
☐ RINVOQ	☐ 15mg Tablet ☐ 30mg Tablet	☐ Induction Dose: Take 45mg by mouth once daily for 8 weeks		
	☐ 45mg Tablet	☐ Maintenance Dose: Take __________mg by mouth once daily		
☐ SKYRIZI	☐ 600mg Vial ☐ 180mg/1.2mL PFC	☐ Induction Dose: Infuse 600mg via IV over 1 hour at week 0, week 4, and week 8	3	0
	☐ 360mg/2.4mL PFC	☐ Maintenance Dose: Inject 180mg SC at week 12 and every 8 weeks thereafter		
		☐ Maintenance Dose: Inject 360mg SC at week 12 and every 8 weeks thereafter		
☐ SIMPONI	☐ 100mg Smartject	☐ Induction Dose: Inject 200mg SC at week 0, then inject 100mg SC at week 2	4	0
	☐ 100mg PFS	☐ Maintenance Dose: Inject 100mg SC once every 4 weeks		
☐ STELARA	☐ 130mg/26mL Vial	☐ Infuse _______mg via IV as a single dose over 60 minutes		
	☐ 90mg/mL PFS	☐ Inject 90mg SC 8 weeks after initial IV dose, then every 8 weeks thereafter		
☐ XELJANZ/XR	☐ 10mg Tablet	☐ Induction Dose: Take 10mg by mouth twice daily for _______ week(s)		
	☐ 5mg Tablet	☐ Maintenance Dose: Take 5mg by mouth twice daily		
	☐ 22mg Tablet	☐ Induction Dose: Take 22mg by mouth once daily for _______ week(s)		
	☐ 11mg Tablet	☐ Maintenance Dose: Take 11mg by mouth once daily		
☐ ZEPOSIA	☐ Starter Pack	☐ Titration: Take 0.23mg by mouth on week 0 and advance as directed	7	
	☐ 0.92mg Capsule	☐ Maintenance Dose: Take 0.92mg by mouth once daily		

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.

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.