

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
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200mg PFS (2 x 200) <input type="checkbox"/> 200 LYO Powder (2 x 200)	<input type="checkbox"/> <u>Induction Dose</u> : Inject 400mg SC at weeks 0, 2, and 4 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 400mg SC every 4 weeks	6	0
<input type="checkbox"/> DUPIXENT	<input type="checkbox"/> 300mg/2mL Pen <input type="checkbox"/> 300mg/2mL PFS	<input type="checkbox"/> Inject 300mg SC once weekly		
<input type="checkbox"/> ENTYVIO	<input type="checkbox"/> 300mg Vial	<input type="checkbox"/> <u>Induction Dose</u> : Infuse 300mg via IV over 30 minutes at weeks 0, 2, and 6 <input type="checkbox"/> <u>Maintenance Dose</u> : Infuse 300mg via IV over 30 minutes 8 weeks after 3 induction doses and continue every 8 weeks	3 1	0
<input type="checkbox"/> HUMIRA (Citrate Free)	<input type="checkbox"/> Crohns/UC Starter (80mg/0.8mL Pen) <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 160mg SC on day 1, then inject 80mg SC on day 15 <input type="checkbox"/> Inject 80mg SC on day 1, then inject 80mg SC on day 2, then inject 80mg SC on day 15 <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	3 3	0 0
<input type="checkbox"/> REMICADE	<input type="checkbox"/> 100mg Vial Weight: _____	<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>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, then 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 initial IV dose, then every 8 weeks thereafter		
<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 payor.

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