Rheumatology & Endocrinology Prescription Referral Form

P-Z

blue sky SPECIALTY PHARMACY

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: _____

PATIENT CLINICAL INFORMATION / HISTORY – PLEASE FORWARD CHART NOTES AND RELEVANT LABS

Diagnosis: _____ ICD 10: _____ Weight:_____ Height: _____ Tb Test Results: _____

Previous / Failed Medications: _____

Drug Allergies: _____

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ RASUVO	☐_____ mg	☐ Inject _____mg SC once weekly		
☐ REMICADE	☐ 100mg Vial Weight: _____	☐ Infuse _____mg/kg intravenously at week 0, week 2, and week 6 ☐ Infuse _____mg/kg intravenously every _____ weeks		
☐ RINVOQ	☐ 15mg ER Tablet	☐ Take 15mg by mouth once daily		
☐ RITUXAN	☐ 500mg/50mL Vial Height: _____ Weight: _____	☐ Infuse 1,000mg intravenously on day 1 and day 15 ☐ Infuse 1,000mg intravenously every 24 weeks		
☐ SIMPONI	☐ 50mg/0.5mL SmartJect ☐ Aria ☐ 50mg/0.5mL PFS	☐ Inject 50mg SC once monthly ☐ Infuse _____mg via IV at weeks 0 and 4, then every 8 weeks thereafter		
☐ STELARA	☐ 45MG PFS ☐ 90MG PFS Weight: _____	☐ Inject 45mg SC on week 0 and week 4 ☐ Inject 90mg SC on week 0 and week 4 ☐ Inject _____mg SC every 12 weeks	1 2	0 0
☐ TALTZ	☐ 80mg Autoinjector ☐ 80mg PFS	☐ Initial Dose: Inject 160mg SC on week 0 ☐ Maintenance Dose: Inject 80mg SC once every 4 weeks ☐ Initial Dose: Inject 160mg SC on week 0 and inject 80mg SC at week 2 ☐ Induction Dose: Inject 80mg SC every 2 weeks (weeks 4-10) ☐ Maintenance Dose: Inject 80mg SC every 4 weeks (starting at week 12)	2 3 2	0 0 1
☐ TREMFYA	☐ 100mg/mL Pen ☐ 100mg/mL PFS	☐ Induction Dose: Inject 100mg SC at week 0 and week 4 ☐ Maintenance Dose: Inject 100mg SC every 8 weeks	2	0
☐ XELJANZ	☐ 5mg Tablet	☐ Take 5mg by mouth twice daily		
☐ XELJANZ XR	☐ 11mg Tablet	☐ Take 11mg 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.