Rheumatology & Endocrinology Prescription Referral Form

A–O

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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
☐ ACTEMRA	☐ 162mg PFS ☐ 162mg ActPen ☐_______ Vial	☐ Inject 162mg SC once weekly ☐ Inject 162mg SC every other week.		
☐ CIMZIA	☐ Cimzia Starter Kit ☐ 200mg PFS ☐ 200 (x2) LVO Powder	☐ Induction Dose: Inject 400mg SC at week 0, at week 2, and at week 4 ☐ Inject ______ mg SC once every ______ weeks		
☐ COSENTYX	☐ 150mg/mL PFS ☐ 150mg/mL Sensoready Pen	☐ Induction Dose: Inject ______ mg SC at weeks 0,1,2,3, and 4 ☐ Maintenance Dose: Inject ______mg SC every 4 weeks		0
☐ ENBREL	☐ 50mg/mL Mini ☐ 50mg/mL PFS ☐ 50mg/mL SureClick	☐ Inject 50mg SC once weekly ☐ Inject ______mg SC ______ a week		
☐ HUMIRA (Citrate Free)	☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL PFS	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once weekly		
	☐ 80mg/0.8mL Pen ☐ 80mg/0.8mL PFS	☐ Inject 80mg SC every other week		
☐ KEVZARA	☐ 150mg PFS ☐ 150mg Pen ☐ 200mg PFS ☐ 200mg Pen	☐ Inject 150mg SC every 2 weeks ☐ Inject 200mg SC every 2 weeks		
☐ KRYSTEXXA	☐ 8mg/mL Vial Weight: ______	☐ Infuse ______mg intravenously every 2 weeks		
☐ OLUMIANT	☐ 2mg Tablet	☐ Take 2mg by mouth once daily		
☐ ORENCIA	☐ 125mg/mL PFS ☐ 125mg/mL Clickject	☐ Inject 125mg SC once weekly		
	☐ 250mg Vial Weight: ______	☐ Induction Dose: Infuse ______mg via IV at week 0, 2, and week 4. ☐ Maintenance Dose: Infuse ______mg via IV every 4 weeks		
☐ OTEZLA	☐ Starter Pack ☐ 30mg Tablets	☐ Induction Dose: Take 1 tablet by mouth on day 1, then increase as directed ☐ Take 30mg by mouth twice daily	55	0
☐ OTREXUP	☐ ______ mg	☐ Inject ______mg SC once weekly		

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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