

Isotretinoin 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 _____
 Urine Pregnancy Test Date: _____ iPledge ID Number: _____

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: Acne Vulgaris Cystic Acne Other _____ ICD 10: L70.0 Other _____
 Weight: _____ Total Cumulative Dose: _____/kg Total Cumulative Dose to Date: _____/kg
 Topicals Failed: _____ Antibiotics Failed: _____
 Drug Allergies: _____

CAN THE PATIENT COMPLY WITH DIETARY RESTRICTIONS REQUIRED FOR GENERIC ISOTRETINOIN? YES NO

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	REFILLS
<input type="checkbox"/> ABSORICA	<input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Take one capsule by mouth twice daily with or without food <input type="checkbox"/> _____	60	0
<input type="checkbox"/> ISOTRETINOIN	<input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> 30mg <input type="checkbox"/> 40mg	<input type="checkbox"/> Take one capsule by mouth once daily with food <input type="checkbox"/> Take one capsule by mouth twice daily with food <input type="checkbox"/> _____	30 60	0 0
CLARAVIS MYORISAN AMNESTEEM ZENATANE				

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.