

Rheumatology & Endocrinology Prescription Referral Form

P-Z



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

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.