

RHEUMATOLOGY A-O

Prescription Referral Form



Phone: 843-352-7662 | Fax: 833-898-3992 | Backup Fax 843-352-7629 | 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

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 ALL CHART NOTES AND LABWORK

Diagnosis: _____ ICD 10: _____ Weight: _____ Height: _____ Tb Test Results: _____
 Drug Allergies: _____ Previous / Failed Medications: _____

PRESCRIBING INFORMATION

NEW RESTART CONTINUING | SHIPPING PREFERENCE: Deliver Medication to Patient Deliver Medication to MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> ACTEMRA	<input type="checkbox"/> 162mg PFS <input type="checkbox"/> 162mg ActPen <input type="checkbox"/> _____ Vial	<input type="checkbox"/> Inject 162mg SC once weekly <input type="checkbox"/> Inject 162mg SC every other week		
<input type="checkbox"/> BIMZELX	<input type="checkbox"/> 160mg PFS <input type="checkbox"/> 160mg Autoinjector	<input type="checkbox"/> Inject 160mg SC once every 4 weeks		
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200 (x2) LVO Powder	<input type="checkbox"/> <u>Induction Dose:</u> Inject 400mg SC at week 0, at week 2, and at week 4 <input type="checkbox"/> Inject _____mg SC once every _____ weeks		
<input type="checkbox"/> COSENTYX	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 150mg/mL Sensoready Pen	<input type="checkbox"/> <u>Induction Dose:</u> Inject _____mg SC at weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject _____mg SC every 4 weeks	0	
<input type="checkbox"/> ENBREL	<input type="checkbox"/> 50mg/mL Mini <input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 50mg/mL SureClick	<input type="checkbox"/> Inject 50mg SC once weekly <input type="checkbox"/> Inject _____mg SC _____ a week		
<input type="checkbox"/> HUMIRA Citrate Free	<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 40mg SC every other week <input type="checkbox"/> Inject 40mg SC once weekly <input type="checkbox"/> Inject 80mg SC every other week		
<input type="checkbox"/> KEVZARA	<input type="checkbox"/> 150mg PFS <input type="checkbox"/> 150mg Pen <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200mg Pen	<input type="checkbox"/> Inject 150mg SC every 2 weeks <input type="checkbox"/> Inject 200mg SC every 2 weeks		
<input type="checkbox"/> KRYSTEXXA Weight: _____	<input type="checkbox"/> 8mg/mL Vial	<input type="checkbox"/> Infuse _____mg via IV every 2 weeks		
<input type="checkbox"/> OLUMIANT	<input type="checkbox"/> 2mg Tablet	<input type="checkbox"/> Take 2mg by mouth once daily		
<input type="checkbox"/> ORENCIA	<input type="checkbox"/> 125mg/mL PFS <input type="checkbox"/> 125mg/mL Clickject <input type="checkbox"/> 250mg Vial	<input type="checkbox"/> Inject 125mg SC once weekly <input type="checkbox"/> <u>Induction Dose:</u> Infuse _____mg via IV at week 0, 2, and week 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Infuse _____mg via IV every 4 weeks		
<input type="checkbox"/> OTEZLA	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Induction Dose: Take 1 tablet by mouth on day 1, then increase as directed <input type="checkbox"/> Take 30mg by mouth twice daily	55	0
<input type="checkbox"/> OTREXUP	<input type="checkbox"/> _____mg	<input type="checkbox"/> Inject _____mg SC once weekly		

PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I authorize Blue Sky Specialty Pharmacy and its 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 payer

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.