Creon
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

First Name: _____ Last Name: _____ Date of Birth: _____ ☐ M ☐ F

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ SSN: _____ **(PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS)**

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____ Contact Person: _____

(PLEASE ATTACH COPY OF MOST RECENT CHART NOTES, PATHOLOGY, AND

PATIENT CLINICAL INFORMATION / HISTORY

Patient Weight	MINIMUM per-meal dose	MAXIMUM per-meal dose
110lb (49.9kg)	36,000 Lipase Units	108,000 Lipase Units
130lb (59.0kg)	36,000 Lipase Units	144,000 Lipase Units
160lb (72.6kg)	72,000 Lipase Units	180,000 Lipase Units
200lb (90.7kg)	72,000 Lipase Units	216,000 Lipase Units
230lb (104.3kg)	72,000 Lipase Units	252,000 Lipase Units

Other Notes: _____

_____

_____

PRESCRIBING INFORMATION

STRENGTH	SIG	QTY	REFILLS
☐ 36,000 Lipase Units ☐ 24,000 Lipase Units ☐ 12,000 Lipase Units ☐ 6,000 Lipase Units ☐ 3,000 Lipase Units	Take _____ capsules during each meal Take _____ capsules during each snack Take during every meal and snack		

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.