Dermatology Prescription Referral Form

P-Z

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: _____

PATIENT CLINICAL INFORMATION / HISTORY

Diagnosis: _____ ICD 10: _____ Weight:_____ Height: _____ Tb Test Results: _____

Drug Allergies:_____ BSA%:_____

Previous / Failed Medications:_____

_____ **(PLEASE FORWARD CHART NOTES AND RELEVANT LABS)**

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ REMICADE	☐ 100mg Vial Weight: _____	☐Infuse _____mg/kg intravenously at weeks 0, week 2, and week 6 ☐Infuse _____mg/kg intravenously every _____ weeks		
☐ SILIQ	☐ 210mg/1.5mL PFS	☐ Induction Dose: Inject 210mg SC at weeks 0, 1, and 2 ☐ Maintenance Dose: Inject 210mg SC every 2 weeks	3	0
☐ SIMPONI	☐ 50mg Pen ☐ 50mg PFS	☐ Inject 50mg SC once monthly		
☐ SKYRIZI	☐ 75mg/0.83mL PFS ☐ 75mg/0.83mL Pen	☐ Induction Dose: Inject 150mg SC at weeks 0 and 4 ☐ Maintenance Dose: Inject 150mg SC every 12 weeks	1	0
☐ STELARA	☐ 45mg/0.5mL PFS ☐ 90mg/mL PFS Weight: _____	☐ Induction Dose: Inject 45mg SC on week 0 and week 4 ☐ Maintenance Dose: Inject 45mg SC every 12 weeks	1	0
		☐ Induction Dose: Inject 90mg SC on week 0 and week 4 ☐ Maintenance Dose: Inject 90mg SC every 12 weeks	2	0
☐ TALTZ	☐ 80mg/mL Autoinjector ☐ 80mg/mL PFS	☐ Initial Dose: Inject 160mg SC at week 0 and inject 80mg SC at week 2 ☐ Induction Dose: Inject 80mg SC every 2 weeks (weeks 4-10) ☐ Maintenance Dose: Inject 80mg SC every 4 weeks(starting week 12)	3 2	0 1
☐ TREMFYA	☐ 100mg/mL Pen ☐ 100mg/mL PFS	☐ Induction Dose: Inject 100mg SC at week 0 and week 4 ☐ Maintenance Dose: Inject 100mg SC every 8 weeks	2	0
☐ _____ ☐ _____	☐ _____ ☐ _____	☐ _____ ☐ _____		

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.