

GASTROENTEROLOGY NON SPECIALTY

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: _____ Drug Allergies: _____
 Previous / Failed Medications: _____
 Notes: _____

PRESCRIBING INFORMATION

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

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> ALINIA	<input type="checkbox"/> 500mg Tablet	<input type="checkbox"/> Take 500mg by mouth twice daily		
<input type="checkbox"/> CREON	<input type="checkbox"/> _____ Lipase Units	<input type="checkbox"/> Take _____ capsules during each meal and _____ during each snack		
<input type="checkbox"/> DIFICID	<input type="checkbox"/> 200mg Tablet	<input type="checkbox"/> Take 200mg by mouth twice daily	20	0
<input type="checkbox"/> IBSRELA	<input type="checkbox"/> 50mg Tablet	<input type="checkbox"/> Take 50mg by mouth twice daily		
<input type="checkbox"/> VEMLIDY	<input type="checkbox"/> 25mg Tablet	<input type="checkbox"/> Take 25mg by mouth twice daily		
<input type="checkbox"/> XIFAXAN	<input type="checkbox"/> 550mg Tablet	<input type="checkbox"/> <u>Irritable Bowel Syndrome</u> : Take 550mg by mouth three times a day	42	
		<input type="checkbox"/> <u>Hepatic Encephalopathy</u> : Take 550mg by mouth twice daily		
<input type="checkbox"/> ZENPEP	<input type="checkbox"/> _____ Lipase Units	<input type="checkbox"/> Take _____ capsules during each meal and _____ during each 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 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.