GASTROENTEROLOGY SPECIALTY A-O
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 - 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: ☐ K50.9 (CROHNS) ☐ K51.90 (UC) ☐ ______________

Weight: ______ Height: ______ Tb Test Results: ______ Date Completed: ______ Latex Allergy: ☐ Yes ☐ No

Previous / Failed Medications: ______________

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver Medication to Patient ☐ Deliver Medication to MDO for First Fill

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ **CIMZIA**	☐ Cimzia Starter Kit ☐ 200mg PFS (2 x 200) ☐ 200 LYO Powder (2 x 200)	☐ Induction Dose: Inject 400mg SC at weeks 0, 2, and 4	6	0
		☐ Maintenance Dose: Inject 400mg SC every 4 weeks		
☐ **DUPIXENT**	☐ 300mg/2mL Pen ☐ 300mg/2mL PFS	☐ Inject 300mg SC once weekly		
☐ **ENTYVIO**	☐ 300mg Vial ☐ 108mg/0.68mL PFS ☐ 108mg/0.68mL Pen	☐ Induction Dose: Infuse 300mg via IV over 30 minutes at weeks 0, 2, and 6	3	0
		☐ Maintenance Dose: Infuse 300mg via IV over 30 minutes 8 weeks after 3 induction doses and continue every 8 weeks	1	
		☐ Maintenance Dose: Inject 108mg SC every 2 weeks (starting at week 6)		
☐ **HUMIRA** Citrate Free	☐ Crohns/UC Starter (80mg/0.8mL Pen)	☐ Inject 160mg SC on day 1, then inject 80mg SC on day 15	3	0
		☐ Inject 80mg SC on day 1, then inject 80mg SC on day 2, then inject 80mg SC on day 15	3	0
	☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL PFS ☐ 80mg/0.8mL Pen	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once weekly ☐ Inject 80mg SC every other week		

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

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