

# RHEUMATOLOGY P-Z

## 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"/> RASUVO	<input type="checkbox"/> _____ mg	<input type="checkbox"/> Inject _____mg SC once weekly		
<input type="checkbox"/> REMICADE Weight: _____	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Infuse _____mg/kg intravenously at week 0, week 2, and week 6 <input type="checkbox"/> Infuse _____mg/kg intravenously every _____ weeks		
<input type="checkbox"/> RINVOQ	<input type="checkbox"/> 15mg ER Tablet	<input type="checkbox"/> Take 15mg by mouth once daily		
<input type="checkbox"/> RITUXAN Weight: _____ Height: _____	<input type="checkbox"/> 500mg/50mL Vial	<input type="checkbox"/> Infuse 1,000mg intravenously on day 1 and day 15 <input type="checkbox"/> Infuse 1,000mg intravenously every 24 weeks		
<input type="checkbox"/> SIMPONI	<input type="checkbox"/> 50mg/0.5mL Smartject <input type="checkbox"/> 50mg/0.5mL PFS <input type="checkbox"/> Aria	<input type="checkbox"/> Inject 50mg SC once monthly <input type="checkbox"/> Infuse _____mg via IV at weeks 0 and 4, then every 8 weeks thereafter		
<input type="checkbox"/> SKYRIZI	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 150mg/mL Pen	<input type="checkbox"/> <u>Induction Dose:</u> Inject 150mg SC at weeks 0 and 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 150mg SC every 12 weeks	2	0
<input type="checkbox"/> STELARA Weight: _____	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/mL PFS	<input type="checkbox"/> <u>Induction Dose:</u> Inject 45mg SC on week 0 and week 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 45mg SC every 12 weeks	1	0
		<input type="checkbox"/> <u>Induction Dose:</u> Inject 90mg SC on week 0 and week 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 90mg SC every 12 weeks	2	0
<input type="checkbox"/> TALTZ Weight: _____	<input type="checkbox"/> 80mg Autoinjector <input type="checkbox"/> 80mg PFS	<input type="checkbox"/> <u>Initial Dose:</u> Inject 160mg SC on week 0 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 80mg SC once every 4 weeks	2	0
		<input type="checkbox"/> <u>Initial Dose:</u> Inject 160mg SC on week 0 and inject 80mg SC at week 2 <input type="checkbox"/> <u>Induction Dose:</u> Inject 80mg SC every 2 weeks (weeks 4-10) <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 80mg SC every 4 weeks (starting at week 12)	3	0
			2	1
<input type="checkbox"/> TREMFYA	<input type="checkbox"/> 100mg/mL Pen <input type="checkbox"/> 100mg/mL PFS	<input type="checkbox"/> <u>Induction Dose:</u> Inject 100mg SC at week 0 and week 4 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 100mg SC once every 8 weeks	2	0
<input type="checkbox"/> XELJANZ	<input type="checkbox"/> 5mg Tablet	<input type="checkbox"/> Take 5mg by mouth twice daily		
<input type="checkbox"/> XELJANZ XR	<input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> Take 11mg by mouth once daily		

### 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.