

Gastroenterology – Non Specialty
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

Prescriber 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 CHART NOTES AND RELEVANT LABS

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 MD

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> ALINIA	<input type="checkbox"/> 500mg Tablet	<input type="checkbox"/> Take 1 tablet 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 1 tablet by mouth once daily		
<input type="checkbox"/> XIFAXAN	<input type="checkbox"/> 550mg Tablet	<input type="checkbox"/> <u>Irritable Bowel Syndrome</u> ; Take 1 tablet by mouth three times a day	42	
		<input type="checkbox"/> <u>Hepatic Encephalopathy</u> ; Take 1 tablet 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 payor.