

# CREON 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 ATTACH COPY OF THE MOST RECENT CHART NOTES, PATHOLOGY, AND LABWORK

Patient Weight	MINIMUM per-meal dose	MAXIMUM per-meal dose
110 lb   49.9kg	36,000 Lipase Units	108,000 Lipase Units
130lb   59.0kg	36,000 Lipase Units	144,000 Lipase Units
160lb   72.6kg	72,000 Lipase Units	180,000 Lipase Units
200lb   90.7kg	72,000 Lipase Units	216,000 Lipase Units
230lb   104.3kg	72,000 Lipase Units	252,000 Lipase Units

Other Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## PRESCRIBING INFORMATION

STRENGTH	SIG	QTY	RFLS
<input type="checkbox"/> 36,000 Lipase Units <input type="checkbox"/> 24,000 Lipase Units <input type="checkbox"/> 12,000 Lipase Units <input type="checkbox"/> 6,000 Lipase Units <input type="checkbox"/> 3,000 Lipase Units	Take _____ capsules during each meal Take _____ capsules during each snack Take during every meal and snack		
		Number of Meals: _____ Number of Snacks: _____	

## 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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