CREON
Prescription Referral Form

blue sky SPECIALTY PHARMACY

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
☐ **36,000** Lipase Units ☐ **24,000** Lipase Units ☐ **12,000** Lipase Units ☐ **6,000** Lipase Units ☐ **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