

UK Contract Specialty Pharmacy Referral Form

Adult and Pediatric Cystic Fibrosis



UK Specialty Phone 844-730-5913

UK Specialty Pulmonary Fax 859-257-8626

PATIENT INFORMATION:

Patient Name: _____
Last First Middle

Patient Address: _____
Street Apt. /Lot, etc. City State Zip

Patient Date of Birth: ____/____/____ **Easy Open Caps:** Yes or No **Gender:** M or F
MM DD Year

Patient Phone Number (primary): (____) _____ **Patient Social Security Number:** _____

Alternative Phone Number (secondary): (____) _____ ###-##-####

Emergency Contact: _____
(Different from Patient Phone #) Name Phone Number Relationship

Patient Height: _____ cm **Patient Weight:** _____ kg **Patient Language:** _____

Allergies: _____

Other Medications: _____

(Please provide printed list, if possible)

INSURANCE INFORMATION:

(Please provide copy of card – Front and back)

Primary Medical Insurance: _____
Plan Name Patient ID Number Plan Phone Number

Primary Prescription Insurance: _____
Plan Name Patient ID Number Plan Phone Number

BIN PCN Rx Group

SHIPMENT PREFERENCES:

FedEx to Patient Home

Or

Clinic Pick-Up – Clinic/Address/Attn to: _____

Or

Other (Please Specify) _____

DIAGNOSIS INFORMATION:

Diagnosis: _____

ICD-10 Code: _____

Diagnosis Date: _____

Genetic Mutations: _____

(Please provide printed copy, if possible)

Other Pertinent Information: _____

PRESCRIPTION INFORMATION:

Prescribing Physician: _____ NPI: _____

Physician Address: _____

Physician Contact Number: _____ Contact Person: _____

Cystic Fibrosis Medication: _____

Fill Type: New Start or Continuation of Therapy

Anticipated Start Date: _____

Anticipated Length of Treatment: _____

REQUIRED DOCUMENTATION:

Please include:

Copy of All Insurance Cards (Front and Back)

Copy of clinical notes, pertinent labs, spirometry results, genetic mutation analysis (or Newborn State Screen results), etc

Copy of Prescription

Signed Permission to Communicate

Signed 3rd Party Release for Copay Assistance

PA Approval

Patient Management by UK Specialty Pharmacy: Yes No

By signing below, I choose to opt out of UK Specialty Pharmacy Patient Management Program.

Refill Management will continue.

Pt signature: _____ Date: _____

Referral Facility: _____

Referral Contact: _____