UK Specialty Contract Pharmacies
UK Specialty Pharmacy GI – IBD Referral Form

UK Specialty Phone 844-730-5913 UK Specialty GI Fax 859-257-3089

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 :_(____)_____________________ **Patient Social Security Number**: ______________________
###-##-####

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

Patient Height: ________inches **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: ______________________________ Previously treated? Y N

Previous Therapies Tried with Outcomes (including dates):____
____
____
____
____

Other Pertinent Information: ____
____
____
____
____

PRESCRIPTION INFORMATION:

Prescribing Physician: ______________________________ NPI: ______________________________

Physician Address: ____

Physician Contact Number: ______________________________ Contact Person: ______________________________

Fill Type: New Start or Continuation of Therapy

Anticipated Start Date: ______________________________

REQUIRED DOCUMENTATION:

Please include:
Copy of All Insurance Cards (Front and Back)
Copy of clinical notes, current pertinent lab results (including TB, Hepatitis screening), scans, colonoscopy reports, pathology, cytology, recent operative reports, etc.
Copy of Prescription
Signed Permission to Communicate
Signed 3rd Party Release for Copay Assistance
PA Approval