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: ____