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: _____