Sterling SPECIALTY PHARMACY

Ancillary Immunology
Prescription Referral Form
NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

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1 Patient Information
Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

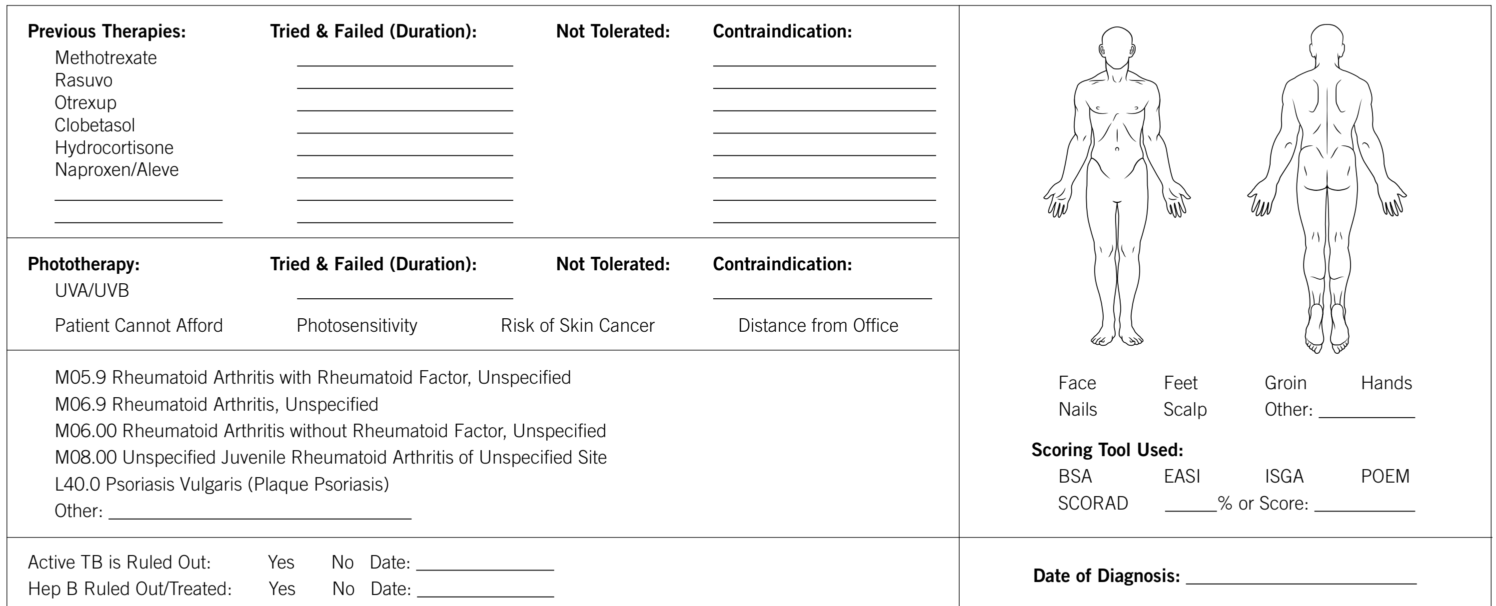
Patient Name: ______ Birthdate: ______ Sex: Male Female Height: ______ Weight: ______ lbs. kg.

Allergies: ______ Patient Primary Language: English Spanish Other: ______ Hearing Impaired

Patient Phone: ______ Patient Email: ______ Caregiver Name: ______

Patient Address: ______ City: ______ State: ______ Zip: ______

2 Diagnosis/Clinical Information
Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.



Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
Methotrexate	______		______
Rasuvo	______		______
Otrexup	______		______
Clobetasol	______		______
Hydrocortisone	______		______
Naproxen/Aleve	______		______
______	______		______
______	______		______

Phototherapy:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
UVA/UVB	______		______

Patient Cannot Afford Photosensitivity Risk of Skin Cancer Distance from Office

M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
M06.9 Rheumatoid Arthritis, Unspecified
M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
Other: ______

Face Feet Groin Hands
Nails Scalp Other: ______

Scoring Tool Used:
BSA EASI ISGA POEM
SCORAD ______% or Score: ______

Active TB is Ruled Out: Yes No Date: ______
Hep B Ruled Out/Treated: Yes No Date: ______

Date of Diagnosis: ______

3 Prescription Information
Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
OTREXUP®	10mg Auto Injector 12.5mg Auto Injector 15mg Auto Injector 17.5mg Auto Injector 20mg Auto Injector 22.5mg Auto Injector 25mg Auto Injector	Inject SQ every week. Other: ______	4 ___	___
______	______	______	___	___

4 Provider/Prescriber Information

Clinic Name: ______ Provider Name: ______

Provider Phone: ______ Provider Fax: ______ DEA#: ______ NPI#: ______

Provider Address: ______ City: ______ State: ______ Zip: ______

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Signature: ______ Date: ______ Dispense as Written (Write "DAW")

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.

IMPORTANT NOTICE: This fax is intended to be delivered to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.