Sterling SPECIALTY PHARMACY

Antipsychotic
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.

Date Medication Needed:_____ **Ship to:** ❑ Patient's Home ❑ Prescriber's Office ❑ Pharmacy to Coordinate

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: _____ Secondary Phone:_____ Patient Email:_____ Caregiver Name:_____

Patient Address:_____ City:_____ State:_____ Zip:_____

2 Provider/Prescriber Information

Clinic Name:_____ Provider Name:_____ DEA#:_____ NPI#:_____

Provider Address:_____ City:_____ State:_____ Zip:_____

Key Contact:_____ Phone:_____ Fax:_____ Email:_____

3 Diagnosis/Clinical Information

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

Date of Diagnosis: _____ ICD-10: _____ Other: _____

❑ Acute ❑ Chronic Contraindications: ❑ No ❑ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure: Date Performed: Results:

_____ _____ _____

_____ _____ _____

Injection Training: ❑ Pharmacist to Provide ❑ Patient Trained in MD Office

If Prior Authorization is Denied: Sterling will inform provider of preferred formulary alternatives and/or draft an appeal letter as advisable.

Prior Failed Treatments:	Drug Name & Length of Treatment:

4 Prescription Information

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

Patient Name:_____ Patient Birthdate:_____

Medication	Dose/Strength	Direction	Qty.	Refills
❑ ABILIFY MAINTENA®	❑ 300mg Prefilled Syringe ❑ 400mg Prefilled Syringe	❑ Inject IM once monthly ❑ _____	❑ 1 ❑ ___	
❑ ARISTADA®	❑ 441mg Prefilled Syringe ❑ 662mg Prefilled Syringe ❑ 882mg Prefilled Syringe ❑ 1064mg Prefilled Syringe	❑ Inject IM every 4 weeks ❑ Inject IM every 6 weeks ❑ Inject IM every 8 weeks ❑ _____	❑ 1 ❑ ___	
❑ INVEGA SUSTENNA®	❑ 39mg Prefilled Syringe ❑ 78mg Prefilled Syringe ❑ 117mg Prefilled Syringe ❑ 156mg Prefilled Syringe ❑ 234mg Prefilled Syringe	❑ **Induction Dose:** Inject 234mg IM on day 1 followed by 156mg 1 week later, then switch to maintenance dose. ❑ **Maintenance Dose:** Inject IM once monthly ❑ _____	❑ 1 ❑ ___	
❑ INVEGA TRINZA®	❑ 273mg Prefilled Syringe ❑ 410mg Prefilled Syringe ❑ 546mg Prefilled Syringe ❑ 819mg Prefilled Syringe	❑ Inject IM every 3 months ❑ _____	❑ 1 ❑ ___	
❑ LATUDA®	❑ 20mg Tablet ❑ 40mg Tablet ❑ 60mg Tablet ❑ 80mg Tablet ❑ 120mg Tablet	❑ Take one tablet by mouth once daily ❑ _____	❑ 30 ❑ ___	
❑ RISPERDAL CONSTA IM®	❑ 12.5mg Prefilled Syringe ❑ 25mg Prefilled Syringe ❑ 37.5mg Prefilled Syringe ❑ 50mg Prefilled Syringe	❑ Inject IM every 2 weeks ❑ _____	❑ 2 ❑ ___	
❑ RISPERDAL CONSTA SQ®	❑ 90mg Prefilled Syringe ❑ 120mg Prefilled Syringe	❑ Inject SQ once monthly ❑ _____	❑ 1 ❑ ___	
❑ ZYPREXA RELPREVV®	❑ 210mg Kit ❑ 300mg Kit ❑ 405mg Kit	❑ Inject IM every 2 weeks ❑ _____	❑ 2 ❑ ___	
		❑ Inject IM every 4 weeks ❑ _____	❑ 1 ❑ ___	
❑ _____	❑ _____	❑ _____	❑ ___	

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

Dispense as written:_____ Date:_____ Substitution Permissible: _____ Date:_____

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.

# of Prescriptions:_____