Antipsychotic
Prescription Referral Form (A to N)
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

Prior Failed Treatments:	Drug Name & Length of Treatment:

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

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 ☐ ___	
☐ ________	☐ ________	☐ ________	☐ ___	

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.

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.

# of Prescriptions:________

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