



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 |
|---|--|--|--|---------|
| <input type="checkbox"/> PERSERIS™ | <input type="checkbox"/> 90mg Prefilled Syringe <input type="checkbox"/> 120mg Prefilled Syringe | <input type="checkbox"/> Inject SQ once monthly <input type="checkbox"/> _____ | <input type="checkbox"/> 1 <input type="checkbox"/> _____ | |
| <input type="checkbox"/> RISPERDAL CONSTA IM® | <input type="checkbox"/> 12.5mg Prefilled Syringe <input type="checkbox"/> 25mg Prefilled Syringe <input type="checkbox"/> 37.5mg Prefilled Syringe <input type="checkbox"/> 50mg Prefilled Syringe | <input type="checkbox"/> Inject IM every 2 weeks <input type="checkbox"/> _____ | <input type="checkbox"/> 2 <input type="checkbox"/> _____ | |
| <input type="checkbox"/> RISPERDAL CONSTA SQ® | <input type="checkbox"/> 90mg Prefilled Syringe <input type="checkbox"/> 120mg Prefilled Syringe | <input type="checkbox"/> Inject SQ once monthly <input type="checkbox"/> _____ | <input type="checkbox"/> 1 <input type="checkbox"/> _____ | |
| <input type="checkbox"/> ZYPREXA RELPREV® | <input type="checkbox"/> 210mg Kit <input type="checkbox"/> 300mg Kit <input type="checkbox"/> 405mg Kit | <input type="checkbox"/> Inject IM every 2 weeks <input type="checkbox"/> _____ | <input type="checkbox"/> 2 <input type="checkbox"/> _____ | |
| | | <input type="checkbox"/> Inject IM every 4 weeks <input type="checkbox"/> _____ | <input type="checkbox"/> 1 <input type="checkbox"/> _____ | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | |

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: _____