



**Sterling**  
SPECIALTY PHARMACY

**Atopic Dermatitis  
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.



**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.

Diagnosis/ICD-10: \_\_\_\_\_ Diagnosis Date: \_\_\_\_\_ Other: \_\_\_\_\_

**Prior Failed Treatments:** Must be completed for all patients.

Assessment: Moderate Moderate to Severe Severe

\_\_\_\_\_% BSA Affected BSA Scoring Tool Name: \_\_\_\_\_

Face Hands Neck Legs Chin Wrists Other: \_\_\_\_\_

Patient also using topical steroids? Yes No Serious or active infection present? Yes No

Treatment Type:	Drug Name:	Dates of Use:
Topicals	_____	_____
Oral Meds	_____	_____
Biologics	_____	_____
Other: _____	_____	_____



**3 Prescription Information**

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

Medication	Dose/Strength	Direction	Qty.	Refills
DUPIXENT®	300mg/2ml Prefilled Syringe	<b>Induction Dose:</b> Inject 600mg SQ on day one. Other: _____	2 ____	0
		<b>Maintenance Dose:</b> Inject 300mg SQ every two weeks. Other: _____	2 ____	____
		<b>Sharps Container:</b> Use as directed with injectable products. (Qty: 1)		
EUCRISA™	2% Ointment, 60g Tube	Apply a thin layer twice daily on affected areas. Other: _____	1 ____	____
_____	_____	_____	____	____



**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.