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: _____

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

Prior Failed Treatments: Must be completed for all patients.

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	❑ **Induction Dose:** Inject 600mg SQ on day one. ❑ Other: _____	❑ 2 ❑ ___	0
		❑ **Maintenance Dose:** Inject 300mg SQ every two weeks. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
		☑ **Sharps Container:** 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.