Sterling SPECIALTY PHARMACY

Behavioral Health
Prescription Referral Form (O to Z)

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: _____

❑ Acute ❑ Chronic Contraindications: ❑ No ❑ Yes _____

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

Test/Procedure:	Date Performed:	Results:

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
❑		
❑		
❑		
❑		
❑		

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
❑ PERSERIS™	❑ 90mg Prefilled Syringe ❑ 120mg Prefilled Syringe	❑ Inject SQ once monthly. ❑ Other: _____	❑ 1 ❑ _____	❑ ___
❑ RISPERDAL CONSTA IM®	❑ 12.5mg Prefilled Syringe ❑ 25mg Prefilled Syringe ❑ 37.5mg Prefilled Syringe ❑ 50mg Prefilled Syringe	❑ Inject IM every 2 weeks. ❑ Other: _____	❑ 2 ❑ _____	❑ ___
❑ RISPERDAL CONSTA SQ®	❑ 90mg Prefilled Syringe ❑ 120mg Prefilled Syringe	❑ Inject SQ once monthly. ❑ Other: _____	❑ 1 ❑ _____	❑ ___
❑ SPRAVATO®	❑ 56mg (28mg Device x 2) ❑ 84mg (28mg Device x 3)	❑ **Induction**: Administer 1 spray per nostril twice weekly at weeks 0, 1, 2, and 3. ❑ Other: _____	❑ 4 boxes ❑ _____	❑ ___
		❑ **Maintenance**: Administer 1 spray per nostril one time per week on weeks 4, 5, 6, and 7. Starting at week 8, continue to use one time weekly or decrease to every 2 weeks. ❑ Other: _____	❑ 2 boxes ❑ _____	❑ ___
❑ VIVITROL®	❑ 380mg Vial Kit	❑ Inject 380mg IM every 4 weeks. ❑ Other: _____	❑ 1 ❑ _____	❑ ___
❑ VRAYLAR®	❑ 1.5mg Capsule ❑ 3mg Capsule ❑ 4.5mg Capsule ❑ 6mg Capsule	❑ Other: _____	❑ _____	❑ ___
❑ ZYPREXA RELPREVV®	❑ 210mg Kit ❑ 300mg Kit ❑ 405mg Kit	❑ Inject IM every 2 weeks. ❑ Other: _____	❑ 2 ❑ _____	❑ ___
		❑ Inject IM every 4 weeks. ❑ 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.