



**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 \_\_\_\_\_

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"/> _____	<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"/> _____	<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: \_\_\_\_\_