Human Immunodeficiency Virus
Prescription Referral Form

Sterling SPECIALTY PHARMACY

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.

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.

Diagnosis/ICD-10: _____ Diagnosis Date: _____ Other: _____

Patient is currently on medications: ❑ Yes ❑ No If so, how long: _____

This medication is for: ❑ PEP ❑ PrEP ❑ Treatment

If Prior Authorization is Denied: Sterling will inform provider of preferred formulary alternatives and/or draft an appeal letter as advisable.

Tried & Failed Medication(s):	**Contraindication(s) to Medications:**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

4 Prescription Information

Patient Name: _____ Patient Birthdate: _____

Medication				Strength/Directions	Qty.	Refills
Combinations						
❑ ATRIPLA®	❑ DESCOVY®	❑ ODEFSEY®	❑ TRIZIVIR®	Strength: _____ Directions: _____	___	
❑ BIKTARVY®	❑ EPZICOM®	❑ PREZCOBIX®	❑ TRUVADA®			
❑ COMBIVIR®	❑ JULUCA™	❑ STRIBILD®				
❑ COMPLERA®	❑ GENVOYA®	❑ TRIUMEQ®				
NRTIs/NNRTIs						
❑ EDURANT®	❑ INTELENCE®	❑ VIRAMUNE XR®		Strength: _____ Directions: _____	___	
❑ EMTRIVA®	❑ SUSTIVA®	❑ VIREAD®				
❑ EPIVIR®	❑ VIRAMUNE®	❑ ZIAGEN®				
Protease Inhibitors						
❑ APTIVUS®	❑ KALETRA®	❑ NORVIR® TABLETS	❑ VIRACEPT®	Strength: _____ Directions: _____	___	
❑ EVOTAZ™	❑ LEXIVA®	❑ PREZISTA®				
❑ INVIRASE®	❑ NORVIR® CAPSULES	❑ REYATAZ®				
Integrase Inhibitor/CCR5 I						
❑ ISENTRESS®	❑ SELZENTRY®	❑ TIVICAY®	❑ VITEKTA™	Strength: _____ Directions: _____	___	
Supportive Medications						
❑ ACYCLOVIR™	❑ DAPSONE™	❑ TYBOST®	❑ ZITHROMAX®	Strength: _____ Directions: _____	___	
❑ BACTRIM®	❑ DIFLUCAN®	❑ VALCYTE®				
❑ BACTRIM® DS	❑ FUZEON®	❑ VALTREX®				
Other						
❑ _____				Strength: _____ Directions: _____	___	

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:_____

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