Hypercholesterolemia
Prescription Referral Form

Sterling SPECIALTY PHARMACY

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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:________

Contraindications: Fibrates ☐ Yes ☐ No Statin ☐ Yes ☐ No Niacin ☐ Yes ☐ No

If yes: ☐ Myopathy or Rhabdomyolysis ☐ Hepatic Disease ☐ Renal Dysfunction ☐ Pregnancy or Lactation

☐ Recent Stroke or TIA ☐ Other:________

Laboratory Tests:

☐ Lipid Panel ☐ No ☐ Yes Date:______

☐ Liver Function ☐ No ☐ Yes Date:______

☐ Renal Function ☐ No ☐ Yes Date:______

Prior Failed Treatments:	**Drug Name & Length of Treatment:**
☐ Fibrates	______
☐ Niacin	______
☐ Zetia	______
☐ Statin	______
☐ Others	______

If labs must be obtained from another prescriber, please indicate name here: __________

Injection Training: ☐ Pharmacist to Provide ☐ Patient Trained in MD Office

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
☐ PRALUENT™	☐ 75mg/ml Prefilled Pen	☐ Inject 75mg SC every 2 weeks ☐ ______	☐ 2 ☐ ___	
	☐ 150mg/ml Prefilled Pen	☐ Inject 150mg SC every 2 weeks ☐ Inject 300mg SC every 4 weeks ☐ ______	☐ 2 ☐ ___	
☐ REPATHA™	☐ 140mg/ml SureClick® Auto Injector	☐ Inject 140mg SC every 2 weeks ☐ ______	☐ 2 ☐ ___	
		☐ Inject 420mg SC once a month (Inject three 140mg/ml injections consecutively within 30 minutes) ☐ ______	☐ 3 ☐ ___	
	☐ 420mg/3.5ml Pushtronex® System ☐ 140mg/ml Prefilled Syringe	☐ Inject single use Pushtronex® system on body with prefilled cartridge ☐ ______	☐ 1 Pack ☐ ___	
☐ ______	☐ ______	☐ ______	☐ ___	___
☐ ______	☐ ______	☐ ______	☐ ___	___
☐ ______	☐ ______	☐ ______	☐ ___	___

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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