Inflammatory Bowel Disease
Prescription Referral Form (A to N)

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:_____

TB Test: ❑ Positive ❑ Negative Date:_____ Hep B ruled out or treatment started? ❑ Yes ❑ No

❑ Chron's Disease ❑ Ulcerative Colitis ❑ Irritable Bowel Syndrome Serious or active infection present? ❑ Yes ❑ No

Injection Training:
- ❑ Pharmacist to Provide
- ❑ Patient Trained in MD Office
- ❑ Manufacturer Nurse Support

Prior Failed Treatments: / **Indicate Drug Name and Length of Treatment:**
- ❑ 5-ASA _____
- ❑ Biologics _____
- ❑ Corticosteroids _____
- ❑ Immunosuppresants _____
- ❑ Methotrexate _____
- ❑ Surgery _____
- ❑ Others _____

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
❑ CIMZIA®	❑ Prefilled Syringe Starter Kit	❑ **Induction Dose:** Inject 400mg SC on day 1, day 14, and day 28	6	0
	❑ 200mg/ml Prefilled Syringe ❑ 200mg Lyophilized Powder Vial	❑ **Maintenance:** Inject 400mg SC every 4 weeks ❑ Other: _____	2	
❑ ENTYVIO®	❑ 300mg Vial	❑ **Induction Dose:** Infuse 300mg intravenously over approximately 30 minutes at 0, 2, and 6 weeks	3	0
		❑ **Maintenance:** Infuse 300mg intravenously over approximately 30 minutes every 8 weeks	1	
❑ HUMIRA® ❑ Patient has signed HUMIRA® Complete form	❑ Chron's Disease/Uveitis Starter Package **(Citrate-Free)**	❑ **Induction:** Inject 160mg SC on day 1, then 80mg SC on day 15, then 40mg SC every other week	3	0
	❑ 40mg/0.4ml Pen **(Citrate-Free)** ❑ 40mg/0.4ml Prefilled Syringe **(Citrate-Free)**	❑ **Maintenance:** Inject 40mg SC every other week ❑ Other: _____	2	
❑ _____	❑ _____	❑ _____		
❑ _____	❑ _____	❑ _____		
❑ _____	❑ _____	❑ _____		

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Dispense as written:_____ Date:_____ Substitution Permissable:_____ 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:_____