



**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  
 Crohn'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:**

- 5-ASA \_\_\_\_\_
- Biologics \_\_\_\_\_
- Corticosteroids \_\_\_\_\_
- Immunosuppressants \_\_\_\_\_
- Methotrexate \_\_\_\_\_
- Surgery \_\_\_\_\_
- Others \_\_\_\_\_

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