Inflammatory Bowel Disease
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:_____

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

❑ Chron's Disease ❑ Ulcerative Colitis ❑ Irritable Bowel Syndrom 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	
❑ HUMIRA® ❑ Patient has signed HUMIRA® Complete form	❑ Chron's Disease/Uveitis Starter Package	❑ **Induction:** Inject 160mg SC on day 1, then 80mg SC on day 15, then 40mg SC every other week	6	0
	❑ 40mg/0.8ml Pen ❑ 40mg/0.89ml Prefilled Syringe	❑ **Maintenance:** Inject 40mg SC every other week ❑ Other: _____	4	
	❑ 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	
❑ SIMPONI®	❑ 100mg/ml SmartJect® Autoinjector	❑ **Induction Dose:** Inject 200mg SC at week 0, then 100mg SC at week 2, and then switch to maintenance dose	3	0
	❑ 100mg/ml Prefilled Syringe	❑ **Maintenance:** Inject 100mg SC every 4 weeks	1	
❑ STELARA®	❑ 130mg/26ml Vial	❑ **Induction Dose:** Patient weight, <55kg: 260mg; >55kg to 85kg: 390mg; >85kg: 520mg administered IV		0
	❑ 45mg/0.5ml Prefilled Syringe ❑ 90mg/ml Prefilled Syringe ❑ 45mg/0.5ml Vial	❑ **Maintenance:** Inject 90mg SC 8 weeks after initial IV dose, then every 8 weeks thereafter	1	
❑ UCERIS®	❑ 9mg Tablets	❑ Take one tablet daily in the morning with or without food	30	1
❑ XIFAXAN®	❑ 550mg Tablets	❑ Take one tablet three times daily for 14 days	42	
❑ XELJANZ®	❑ 5mg Tablets ❑ 10mg Tablets	❑ Take one 10mg tablet by mouth twice a day (with or without food) for the first 8 weeks. ❑ Take one 5mg tablet by mouth twice a day with, or without, food ❑ Take one 10 mg tablet by mouth twice a day with, or without, food	60	

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.

# of Prescriptions:_____