



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: _____ Relapse/Remitting Progressive
 If Relapse Remitting: Has the patient experienced a first clinical episode? Yes No Attach MRI Results Date: _____
 Past failed therapies: _____
 Does the patient have any contraindication(s) to therapy? Yes No If Yes: _____

Injection Training: Pharmacist to Provide Patient Trained in MD Office 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
<input type="checkbox"/> AMPYRA®	<input type="checkbox"/> 10mg Tablets	<input type="checkbox"/> Take one tablet by mouth twice daily with, or without, food Note: medication request should be sent to Ampyra hub via ampyra-hcp.com using the Medication Request Form	60	
<input type="checkbox"/> AUBAGIO®	<input type="checkbox"/> 7mg Tablets <input type="checkbox"/> 14mg Tablets	<input type="checkbox"/> Take one tablet by mouth once daily with, or without, food	30	
<input type="checkbox"/> AVONEX®	<input type="checkbox"/> 30mcg Prefilled Syringe <input type="checkbox"/> 30mcg Single Dose Vial <input type="checkbox"/> 30mcg Avonex® Pen	<input type="checkbox"/> Inject 30mcg IM once a week <input type="checkbox"/> Tritration: 7.5mcg weekly (over a 4 week period) until target dose of 30mcg is reached	1 Pack	
<input type="checkbox"/> BETASERON®	<input type="checkbox"/> 0.3mg Lyophilized Powder	<input type="checkbox"/> Inject 0.25mg (1ml) SC every other day <input type="checkbox"/> Tritration: Weeks 1-2: Inject 0.0625mg (0.25ml) SC every other day Weeks 3-4: Inject 0.125mg (0.50ml) SC every other day Weeks 5-6: Inject 0.1875mg (.75ml) SC every other day Weeks 7 and Onward: Inject 0.25mg (1ml) SC every other day	1 Pack	
<input type="checkbox"/> COPAXONE®	<input type="checkbox"/> 20mg Prefilled Syringe <input type="checkbox"/> 40mg Prefilled Syring	<input type="checkbox"/> Inject 20mg SC daily <input type="checkbox"/> Inject 40mg SC three times per week <input type="checkbox"/> Other: _____	1 Pack	
<input type="checkbox"/> EXTAVIA®	<input type="checkbox"/> 0.3mg Lyophilized Powder	<input type="checkbox"/> Inject 0.25mg (1ml) SC every other day <input type="checkbox"/> Tritration: Weeks 1-2: Inject 0.0625mg (0.25ml) SC every other day Weeks 3-4: Inject 0.125mg (0.50ml) SC every other day Weeks 5-6: Inject 0.1875mg (.75ml) SC every other day Weeks 7 and Onward: Inject 0.25mg (1ml) SC every other day	1 Pack	
<input type="checkbox"/> GILENYA®	<input type="checkbox"/> 0.25mg Capsules <input type="checkbox"/> 0.50mg Capsules	<input type="checkbox"/> Patients 10 years of age or older and weighing > 40kg: Take one 0.50mg capsule by mouth once daily with, or without, food <input type="checkbox"/> Patients 10 years of age or older and weighing ≤ 40kg: Take one 0.25mg capsule by mouth once daily with, or without, food	30	
<input type="checkbox"/> GLATOPA™	<input type="checkbox"/> 20mg Prefilled Syringe	<input type="checkbox"/> Inject 20mg SC daily	30	
<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/0H/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____