Sterling SPECIALTY PHARMACY

Multiple Sclerosis
Prescription Referral Form (H to Z)

NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

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.

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: _____ Patient Email: _____ Caregiver Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

2 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: _____

Does the patient have any contraindication(s) to therapy? ❑ Yes ❑ No

If Yes: _____

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
❑		
❑		
❑		
❑		

3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
❑ KESIMPTA®	❑ 20mg/0.4ml Sensoready Pen	❑ **Induction:** Inject 20mg SQ one time weekly for 3 doses on (weeks 0, 1, and 2). ❑ Other: _____	❑ ___	❑ ___
		❑ **Maintenance:** Inject 20mg SQ one time monthly starting on week 4. ❑ Other: _____	❑ ___	❑ ___
❑ OCREVUS®	❑ 300mg/10ml Single Dose Vial	❑ **Induction:** Infuse 300mg via IV over 2.5 hours on day 1 and day 15. Start Maintenance dose six months after first 300mg dose. ❑ Other: _____	❑ 1 ❑ ___	❑ 1 ❑ ___
		❑ **Maintenance:** Infuse 600mg via IV over 3.5 hours every six months. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
❑ PLEGRIDY®	❑ Starter Pack: Plegridy® Pen Injector ❑ Starter Pack: Prefilled Syringe	❑ **Induction:** Inject 63mcg SQ on day 1 and 94mcg on day 15, then start Maintenance dose on day 29. ❑ Other: _____	❑ 1 ❑ ___	❑ 0 ❑ ___
	❑ 125mcg Plegridy® Pen Injector ❑ 125mcg Prefilled Syringe	❑ **Maintenance:** Inject 125mcg SQ every other week. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
❑ REBIF®	❑ Rebidose® Tritration Pack *(Contains six 8.8mcg pre-filled autoinjectors and six 22mcg pre-filled autoinjectors)*	❑ **Tritration Pack:** **Weeks 1 – 2:** Use one 8.8mcg autoinjector three times a week, at least 48 hours apart. **Weeks 3 – 4:** Use one 22mcg autoinjector three times a week, at least 48 hours apart. ❑ Other: _____	❑ 1 Pack ❑ ___	❑ 0 ❑ ___
	❑ 22mcg Rebif® Rebidose® Autoinjector ❑ 44mcg Rebif® Rebidose® Autoinjector ❑ 22mcg Prefilled Syringe ❑ 44mcg Prefilled Syringe	❑ **22mcg Directions:** **Weeks 1 – 2:** Inject 4.4mcg three times a week. **Weeks 3 – 4:** Inject 11mcg three times a week. **Weeks 5 and Onward:** Inject 22mcg three times a week. ❑ **44mcg Directions:** **Weeks 1 – 2:** Inject 8.8mcg three times a week. **Weeks 3 – 4:** Inject 22mcg three times a week. **Weeks 5 and Onward:** Inject 44mcg three times a week. ❑ Other: _____	❑ 1 Pack ❑ ___	❑ ___
❑ TECFIDERA®	❑ Tecfidera® 30-Day Starter Pack *(Contains fourteen 120mg capsules and forty-six 240mg capsules)*	❑ **Starter Pack:** **Week 1:** Take one 120mg capsule by mouth twice a day. **Week 2:** Take one 240mg capsule by mouth twice a day. ❑ Other: _____	❑ 1 Pack ❑ ___	❑ 0 ❑ ___
	❑ 120mg Capsules ❑ 240mg Capsules	❑ Take one 120mg capsule by mouth twice a day. ❑ Take one 240mg capsule by mouth twice a day. ❑ Other: _____	❑ 14 ❑ 60 ❑ ___	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____

Provider Address: _____ City: _____ State: _____ Zip: _____

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

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

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.