



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"/> OCREVUS®	<input type="checkbox"/> 300mg/10ml Single Dose Vial	<input type="checkbox"/> Induction: Infuse 300mg via IV over 2.5 hours on day 1 and day 15. Start Maintenance dose six months after first 300mg dose.	1	1
		<input type="checkbox"/> Maintenance: Infuse 600mg via IV over 3.5 hours every six months	2	
<input type="checkbox"/> PLEGRIDY®	<input type="checkbox"/> Starter Pack: Plegridy® Pen Injector <input type="checkbox"/> Starter Pack: Prefilled Syringe	<input type="checkbox"/> Induction: Inject 63mcg SC on day 1 and 94mcg on day 15, then start Maintenance dose on day 29	1	0
	<input type="checkbox"/> 125mcg Plegridy® Pen Injector <input type="checkbox"/> 125mcg Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject 125mcg SC every other week	2	
<input type="checkbox"/> REBIF®	<input type="checkbox"/> Rebidose® Tritration Pack <i>(contains six 8.8mcg pre-filled autoinjectors and six 22mcg pre-filled autoinjectors)</i>	<input type="checkbox"/> 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	1 Pack	0
	<input type="checkbox"/> 22mcg Rebif® Rebidose® Autoinjector <input type="checkbox"/> 44mcg Rebif® Rebidose® Autoinjector <input type="checkbox"/> 22mcg Prefilled Syringe <input type="checkbox"/> 44mcg Prefilled Syringe	<input type="checkbox"/> 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 <input type="checkbox"/> 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	1 Pack	
<input type="checkbox"/> TECFIDERA®	<input type="checkbox"/> Tecfidera® 30-Day Starter Pack <i>(contains fourteen 120mg capsules and forty-six 240mg capsules)</i>	<input type="checkbox"/> Starter Pack: Week 1: Take one 120mg capsule by mouth twice a day Week 2: Take one 240mg capsule by mouth twice a day	1 Pack	0
	<input type="checkbox"/> 120mg Capsules <input type="checkbox"/> 240mg Capsules	<input type="checkbox"/> Take one 120mg capsule by mouth twice a day <input type="checkbox"/> Take one 240mg capsule by mouth twice a day	14 60	
<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/H/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____

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