Sterling SPECIALTY PHARMACY

Ophthalmology Prescription Referral Form

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.

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:__________

History of MS or other demyelinating disease? ☐ Yes ☐ No
Hep B ruled out or treatment started? ☐ Yes ☐ No
History of malignancy? ☐ Yes ☐ No
Patient also using Topical Steroids? ☐ Yes ☐ No
Contraindiction for antibiotics? ☐ Yes ☐ No
Serious or active infection present? ☐ Yes ☐ No
Does patient have latex allergy? ☐ Yes ☐ No
New onset CHF or worsening CHF? ☐ Yes ☐ No

Injection Training:
- ☐ Pharmacist to Provide
- ☐ Patient Trained in MD Office
- ☐ Manufacturer Nurse Support

Prior Failed Treatments:
- ☐ Antibiotics
- ☐ Methotrexate
- ☐ Steroid Injections
- ☐ Others
- ☐ Immunosuppressants

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
☐ HUMIRA® ☐ Patient has signed HUMIRA® Complete form	☐ Uveitis Starter Pack	☐ **Induction:** Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	4	0
	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ **Maintenance:** Inject 40mg SC every other week ☐ Other: __________	2	
	☐ Uveitis Starter Package **(Citrate-Free)**: (1) 80mg/0.8ml Pen & (2) 40mg/0.4ml Pens	☐ **Induction:** Inject 80mg SC on day 1, then 40mg SC on day 8, 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	
☐ __________	☐ __________	☐ __________		
☐ __________	☐ __________	☐ __________		
☐ __________	☐ __________	☐ __________		
☐ __________	☐ __________	☐ __________		

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:__________

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