Psoriasis
Prescription Referral Form (A to H)
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: ______ LFT: ______ ALT: ______ AST: ______ Date: ______

Assessment: Moderate Moderate to Severe Severe

_____% BSA Affected Hands Scalp Feet Groin Nails

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

Patient also taking Methotrexate?	Yes	No
Serious or active infection present?	Yes	No
Hep B ruled out or treatment started?	Yes	No
Does patient have latex allergy?	Yes	No

Prior Failed Treatments:	**Indicate Drug Name and Length of Treatment:**
Biologicals	
Methotrexate	______
Oral Meds	______
Topicals	______
UVA	______
UVB	______
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®	200mg/ml Prefilled Syringe	**Maintenance:** Inject 400mg SC every other week Other: ______	2 ___	
COSENTYX™	150mg/ml Sensoready® Pen 150mg/ml Prefilled Syringe	**Induction:** Inject 150mg SC at weeks 0, 1, 2, and 3 **Induction:** Inject 300mg SC at weeks 0, 1, 2, and 3 Other: ______	4 8 ___	0
		Maintenance: Inject 150mg SC on week 4 and every 4 weeks thereafter **Maintenance:** Inject 300mg SC on week 4 and every 4 weeks thereafter Other: ______	1 2 ___	
		Refill: Inject 150mg SC every 4 weeks **Refill:** Inject 300mg SC every 4 weeks Other: ______	1 2 ___	
ENBREL®	50mg/ml ENBREL Mini™ with AutoTouch™ 50mg/ml Sureclick® Autoinjector 50mg/ml Prefilled Syringe 25mg/ml Prefilled Syringe 25mg/ml Lyophilized Powder Multiple Dose Vial Other: ______	**Induction:** Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing Other: ______	8 ___	2
		Maintenance: Inject 50mg SC once a week. **Pediatric Patients:** To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder > 138lbs or more: Inject 50mg SC weekly < 138lbs: Inject 0.8mg/kg SC weekly Other: ______	4 ___	
HUMIRA® Patient has signed HUMIRA® Complete form	Psoriasis/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 Other: ______	3 ___	0
	40mg/0.4ml Pen **(Citrate-Free)** 40mg/0.4ml Prefilled Syringe **(Citrate-Free)**	**Maintenance:** Inject 40mg SC every other week Other: ______	2 ___	
	Hidradenitis Suppurativa Starter Package **(Citrate-Free)**: (3) 80mg/0.8ml Pens	**Induction:** Inject 160mg SC on day 1 (or 80mg on day 1 and 80mg on day 2), 80mg SC on day 15, then switch to maintenance dose on day 29 Other: ______	3 ___	0
	40mg/0.4ml Pen **(Citrate-Free)** 40mg/0.4ml Prefilled Syringe **(Citrate-Free)**	**Maintenance:** Inject 40mg SC every week Other: ______	4 ___	
______	______	______	___	

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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