Psoriasis
Prescription Referral Form (A to N)

Sterling SPECIALTY PHARMACY
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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	2	
❑ COSENTYX™	❑ 150mg/ml Sensoready® Pen ❑ 150mg/ml Prefilled Syringe	❑ **Induction:** Inject 150mg SC at weeks 0, 1, 2, and 3	4	0
		❑ **Induction:** Inject 300mg SC at weeks 0, 1, 2, and 3	8	0
		❑ **Maintenance:** Inject 150mg SC on week 4 and every 4 weeks thereafter	1	
		❑ **Maintenance:** Inject 300mg SC on week 4 and every 4 weeks thereafter	2	
		❑ **Refill:** Inject 150mg SC every 4 weeks	1	
		❑ **Refill:** Inject 300mg SC every 4 weeks	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	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	4	
		❑ > 138lbs or more: Inject 50mg SC weekly	4	
		❑ <138lbs: Inject 0.8mg/kg SC weekly		
		❑ Other: _____		
❑ 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	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	3	0
	❑ 40mg/0.4ml Pen **(Citrate-Free)** ❑ 40mg/0.4ml Prefilled Syringe **(Citrate-Free)**	❑ **Maintenance:** Inject 40mg SC every week	2	
❑ ILUMYA®	❑ 100 mg/ml Solution in a Single-Dose Prefilled Syringe	❑ **Induction:** Inject 100 mg SC at weeks 0 and 4	2	0
		❑ **Maintenance:** Inject 100 mg SC every 12 weeks		
❑ _____	❑ _____	❑ _____		
❑ _____	❑ _____	❑ _____		

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.

# of Prescriptions:_____