

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

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> Biologicals	_____
<input type="checkbox"/> Methotrexate	_____
<input type="checkbox"/> Oral Meds	_____
<input type="checkbox"/> Topicals	_____
<input type="checkbox"/> UVA	_____
<input type="checkbox"/> UVB	_____
<input type="checkbox"/> Others	_____

Injection Training: <input type="checkbox"/> Pharmacist to Provide <input type="checkbox"/> Patient Trained in MD Office <input type="checkbox"/> Manufacturer Nurse Support	Patient also taking Methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No Serious or active infection present? <input type="checkbox"/> Yes <input type="checkbox"/> No Hep B ruled out or treatment started? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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.

Medication	Dose/Strength	Direction	Qty.	Refills
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> 200mg/ml Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject 400mg SC every other week	2	
<input type="checkbox"/> COSENTYX™	<input type="checkbox"/> 150mg/ml Sensoready® Pen <input type="checkbox"/> 150mg/ml Prefilled Syringe	<input type="checkbox"/> Induction: Inject 150mg SC at weeks 0, 1, 2, and 3	4	0
		<input type="checkbox"/> Induction: Inject 300mg SC at weeks 0, 1, 2, and 3	8	0
		<input type="checkbox"/> Maintenance: Inject 150mg SC on week 4 and every 4 weeks thereafter	1	
		<input type="checkbox"/> Maintenance: Inject 300mg SC on week 4 and every 4 weeks thereafter	2	
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> 50mg/ml Sensoready® Pen with AutoTouch™ <input type="checkbox"/> 50mg/ml Sureclick® Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/ml Lyophilized Powder Multiple Dose Vial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Induction: Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing	8	2
		<input type="checkbox"/> Maintenance: Inject 50mg SC once a week. Pediatric Patients: To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder	4	
		<input type="checkbox"/> > 138lbs or more: Inject 50mg SC weekly	4	
		<input type="checkbox"/> <138lbs: Inject 0.8mg/kg SC weekly		
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Psoriasis/Uveitis Starter Package (Citrate-Free): (1) 80mg/0.8ml Pen & (2) 40mg/0.4ml Pens <input type="checkbox"/> 40mg/0.4ml Pen (Citrate-Free) <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe (Citrate-Free) <input type="checkbox"/> Hidradenitis Suppurativa Starter Package (Citrate-Free): (3) 80mg/0.8ml Pens <input type="checkbox"/> 40mg/0.4ml Pen (Citrate-Free) <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe (Citrate-Free)	<input type="checkbox"/> Induction: Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	3	0
		<input type="checkbox"/> Maintenance: Inject 40mg SC every other week	2	
		<input type="checkbox"/> 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
		<input type="checkbox"/> Maintenance: Inject 40mg SC every week	4	
<input type="checkbox"/> ILUMYA®	<input type="checkbox"/> 100mg/ml Solution in a Single-Dose Prefilled Syringe	<input type="checkbox"/> Induction: Inject 100mg SC at week 0 <input type="checkbox"/> Maintenance: Inject 100mg SC at week 4 and every 12 weeks thereafter	1	0
<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/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____