Psoriasis
Prescription Referral Form (I to R)
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
ILUMYA®	100mg/ml Solution in a Single-Dose Prefilled Syringe	**Induction:** Inject 100mg SC at week 0 Other: ______	1	0
		Maintenance: Inject 100mg SC at week 4 and every 12 weeks thereafter Other: ______	1	
ORENCIA®	125mg/ml ClickJect™ Autoinjector 125mg/ml Prefilled Syringe	Inject 125mg SC once a week Other: ______	4	
OTEZLA®	Prescriber provided patient with Otezla® 2-week Starter Pack Sample **Date Provided:** ______		0	0
	Starter Pack (Tritration)	**Starter Pack:** Take one tablet by mouth in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack Other: ______	55	
	30mg Tablets	**Maintenance:** Take one 30mg tablet by mouth twice daily Other: ______	60	
	Bridge Rx—30mg of Otezla® (commercial patients only)	**Bridge:** Take one 30mg tablet by mouth: Twice daily (x14 days, 28 tablets, 12 refills) Once daily (x28 days, 28 tablets, 6 refills) Other: ______	___	
REMICADE®	100mg Vial (5mg/kg)	**Induction Dose:** Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks Other: ______	___	0
		Maintenance Dose: Infuse 5mg/kg intravenously over approximately 2 hours every 8 weeks Other: ______	___	
______	______	______	___	

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: ______

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.

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