



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.

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: _____ Patient Email: _____ Caregiver Name: _____
 Patient Address: _____ City: _____ State: _____ Zip: _____

2 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 BSA Scoring Tool Name: _____
 Hands Scalp Feet Groin Nails Other: _____

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
Biologicals	_____	_____
Methotrexate	_____	_____
Oral Meds	_____	_____
Topicals	_____	_____
UVA	_____	_____
UVB	_____	_____
Other: _____	_____	_____

Patient also taking Methotrexate?	Yes	No	Provider has determined that the alternative treatment options would not be as effective as the prescribed medication, and therefore the requested medication is medically necessary.
Serious or active infection present?	Yes	No	
Hep B ruled out or treatment started?	Yes	No	
Does patient have latex allergy?	Yes	No	

3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
ILUMYA®	100mg/ml Solution in a Single-Dose Prefilled Syringe	Induction: Inject 100mg SQ at week 0. Other: _____	1	0
		Maintenance: Inject 100mg SQ at week 4 and every 12 weeks thereafter. Other: _____	1	_____
		Sharps Container: Use as directed with injectable products. (Qty: 1)	_____	_____
ORENCIA®	125mg/ml ClickJect™ Autoinjector 125mg/ml Prefilled Syringe	Inject 125mg SQ once a week. Other: _____	4	_____
		Sharps Container: Use as directed with injectable products. (Qty: 1)	_____	_____
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	_____
OTREXUP®	10mg/0.4ml Autoinjector 12.5mg/0.4ml Autoinjector 15mg/0.4ml Autoinjector 17.5mg/0.4ml Autoinjector 20mg/0.4ml Autoinjector 22.5mg/0.4ml Autoinjector 25mg/0.4ml Autoinjector	Inject SQ every week. Other: _____	4	_____
		Sharps Container: Use as directed with injectable products. (Qty: 1)	_____	_____
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: _____	_____	_____
_____	_____	_____	_____	_____

4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____
 Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____
 Provider Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

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/DH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.