



**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

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:**  
 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

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"/> ORENCIA®	<input type="checkbox"/> 125mg/ml ClickJect™ Autoinjector <input type="checkbox"/> 125mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 125mg SC once a week	4	
<input type="checkbox"/> OTEZLA®	<input type="checkbox"/> Prescriber provided patient with Otezla® 2 week Starter Pack Sample <b>Date Provided:</b> ____/____/____		0	0
	<input type="checkbox"/> Starter Pack (Tritration)	<input type="checkbox"/> <b>Starter Pack:</b> 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	55	
	<input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> <b>Maintenance:</b> Take one 30mg tablet by mouth twice daily	60	
<input type="checkbox"/> REMICADE®	<input type="checkbox"/> 100mg Vial (5mg/kg)	<input type="checkbox"/> <b>Bridge:</b> Take one 30mg tablet by mouth: <input type="checkbox"/> Twice daily (x14 days, 28 tablets, 12 refills) <input type="checkbox"/> Once daily (x28 days, 28 tablets, 6 refills)		
		<input type="checkbox"/> <b>Induction Dose:</b> Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse 5mg/kg intravenously over approximately 2 hours every 8 weeks		0
<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> 50mg/0.5ml SmartJect® Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SC once a month	1	
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe (for < 220 lbs) <input type="checkbox"/> 90mg/1ml Prefilled Syringe (for > 220 lbs)	<input type="checkbox"/> <b>Induction:</b> Inject the contents of 1 prefilled syringe SC on day 1	1	0
		<input type="checkbox"/> <b>Maintenance:</b> Inject the contents of 1 prefilled syringe SC on day 29, and every 12 weeks thereafter	1	
<input type="checkbox"/> TALTZ®	<input type="checkbox"/> 80mg/ml Autoinjector <input type="checkbox"/> 80mg/ml Prefilled Syringe	<input type="checkbox"/> <b>Starting dose:</b> Inject 160mg (2 injections) SC on day 1, then begin Induction of 80mg (1 injection) SC two weeks later (week 2)	3	0
		<input type="checkbox"/> <b>Induction:</b> Inject 80mg SC on weeks 4, 6, 8, and 10	2	1
		<input type="checkbox"/> <b>Maintenance:</b> Inject 80mg SC on week 12, and every 4 weeks thereafter	1	0
		<input type="checkbox"/> <b>Refill:</b> Inject 80mg SC every 4 weeks	1	
<input type="checkbox"/> TREMFYA™	<input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> <b>Induction Dose:</b> Inject 100mg/ml SC at weeks 0 and 4	2	0
		<input type="checkbox"/> <b>Maintenance Dose:</b> Inject 100mg/ml SC every 8 weeks thereafter	1	
<input type="checkbox"/> XELJANZ® <input type="checkbox"/> XELJANZ® XR <small>*Only indicated for the treatment of psoriatic arthritis</small>	<input type="checkbox"/> 5mg Tablet <input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> Take one 5mg tablet by mouth twice a day	60	
		<input type="checkbox"/> Take one 11mg tablet by mouth once a day	30	

**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/0H/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: \_\_\_\_\_