Psoriasis
Prescription Referral Form (O to Z)
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
❑ ORENCIA®	❑ 125mg/ml ClickJect™ Autoinjector ❑ 125mg/ml Prefilled Syringe	❑ Inject 125mg SC once a week	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	55	
	❑ 30mg Tablets	❑ **Maintenance:** Take one 30mg tablet by mouth twice daily	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)		
❑ REMICADE®	❑ 100mg Vial (5mg/kg)	❑ **Induction Dose:** Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks		0
		❑ **Maintenance Dose:** Infuse 5mg/kg intravenously over approximately 2 hours every 8 weeks		
❑ SIMPONI®	❑ 50mg/0.5ml SmartJect® Autoinjector ❑ 50mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC once a month	1	
❑ STELARA®	❑ 45mg/0.5ml Prefilled Syringe (for < 220 lbs) ❑ 90mg/1ml Prefilled Syringe (for > 220 lbs)	❑ **Induction:** Inject the contents of 1 prefilled syringe SC on day 1	1	0
		❑ **Maintenance:** Inject the contents of 1 prefilled syringe SC on day 29, and every 12 weeks thereafter	1	
❑ TALTZ®	❑ 80mg/ml Autoinjector ❑ 80mg/ml Prefilled Syringe	❑ **Starting dose:** Inject 160mg (2 injections) SC on day 1, then begin Induction of 80mg (1 injection) SC two weeks later (week 2)	3	0
		❑ **Induction:** Inject 80mg SC on weeks 4, 6, 8, and 10	2	1
		❑ **Maintenance:** Inject 80mg SC on week 12, and every 4 weeks thereafter	1	0
		❑ **Refill:** Inject 80mg SC every 4 weeks	1	
❑ TREMFYA™	❑ 100mg/ml Prefilled Syringe ❑ 100mg/ml One-Press Injector	❑ **Induction Dose:** Inject 100mg/ml SC at weeks 0 and 4	2	0
		❑ **Maintenance Dose:** Inject 100mg/ml SC every 8 weeks	1	
❑ XELJANZ® ❑ XELJANZ® XR *Only indicated for the treatment of psoriatic arthritis	❑ 5mg Tablet ❑ 11mg Tablet	❑ Take one 5mg tablet by mouth twice a day	60	
		❑ 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.

# 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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