Psoriasis
Prescription Referral Form (O to Z)

Sterling SPECIALTY PHARMACY

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	❑ **Induction Dose:** Inject intravenously 5mg/kg at 0, 2, and 6 weeks, then every 8 weeks thereafter		
		❑ **Maintenance Dose:** Inject intravenously 5mg/kg 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	❑ **Induction Dose:** Inject 100mg/ml SC at weeks 0 and 4	2	0
		❑ **Maintenance Dose:** Inject 100mg/ml SC every 8 weeks thereafter	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:_____