Psoriasis
Prescription Referral Form (S to Z)

Sterling SPECIALTY PHARMACY

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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
❑ SILIQ™	❑ 210mg/1.5mL Prefilled Syringe	❑ **Induction:** Inject the contents of 1 prefilled syringe SC at weeks 0, 1, and 2 ❑ Other: _____	❑ 3 ❑ ___	0
		❑ **Maintenance:** Inject the contents of 1 prefilled syringe SC every 2 weeks ❑ Other: _____	❑ 2 ❑ ___	
❑ SIMPONI®	❑ 50mg/0.5ml SmartJect® Autoinjector ❑ 50mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC once a month ❑ Other: _____	❑ 1 ❑ ___	
❑ SKYRIZI™	❑ 75mg/mL Prefilled Syringe	❑ **Induction:** Inject the contents of 2 prefilled syringes SC at week 0 ❑ Other: _____	❑ 2 ❑ ___	0
		❑ **Maintenance:** Inject the contents of 2 prefilled syringes SC at week 4 and every 12 weeks thereafter ❑ Other: _____	❑ 2 ❑ ___	
❑ 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 ❑ Other: _____	❑ 1 ❑ ___	0
		❑ **Maintenance:** Inject the contents of 1 prefilled syringe SC on day 29, and every 12 weeks thereafter ❑ Other: _____	❑ 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) ❑ Other: _____	❑ 3 ❑ ___	0
		❑ **Induction:** Inject 80mg SC on weeks 4, 6, 8, and 10 ❑ Other: _____	❑ 2 ❑ ___	1
		❑ **Maintenance:** Inject 80mg SC on week 12, and every 4 weeks thereafter ❑ Other: _____	❑ 1 ❑ ___	0
		❑ **Refill:** Inject 80mg SC every 4 weeks ❑ Other: _____	❑ 1 ❑ ___	
❑ TREMFYA™	❑ 100mg/ml Prefilled Syringe ❑ 100mg/ml One-Press Injector	❑ **Induction Dose:** Inject 100mg SC at week 0 ❑ Other: _____	❑ 1 ❑ ___	0
		❑ **Maintenance Dose:** Inject 100mg SC at week 4 and every 8 weeks thereafter ❑ Other: _____	❑ 2 ❑ ___	
❑ XELJANZ® ❑ XELJANZ® XR *Only indicated for the treatment of psoriatic arthritis	❑ 5mg Tablet ❑ 11mg Tablet	❑ Take one 5mg tablet by mouth twice a day ❑ Other: _____	❑ 60 ❑ ___	
		❑ Take one 11mg tablet by mouth once a day ❑ Other: _____	❑ 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:_____