



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: _____

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:
 Azulfidine® Corticosteroids
 Biologics Indocin®
 Calcipotriene Methotrexate
 Celebrex® Other(s)
Indicate Drug Name and Length of Treatment:

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
<input type="checkbox"/> ACTEMRA®	<input type="checkbox"/> 162mg/0.9ml Prefilled Syringe	<input type="checkbox"/> Inject 162mg SC every other week (< 100 kgs)	2	
		<input type="checkbox"/> Inject 162mg SC every week (> 100 kgs)	4	
	<input type="checkbox"/> 80mg/4ml IV Single Dose Vials <input type="checkbox"/> 200mg/10ml IV Single Dose Vials <input type="checkbox"/> 400mg/20ml Single Dose Vials	Polyarticular Juvenile Idiopathic Arthritis (PJIA):		
		<input type="checkbox"/> Inject 162mg SC every 3 weeks (< 30 kgs) <input type="checkbox"/> Inject 162mg SC every other week (≥ 30 kgs)		
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> Prefilled Syringe Starter Kit <input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg Lyophilized Powder Vial	Polyarticular Juvenile Idiopathic Arthritis (PJIA):		
		<input type="checkbox"/> Administer 10mg/kg once every 4 weeks as a 60-minute single IV drip infusion (< 30 kgs) <input type="checkbox"/> Administer 8mg/kg once every 4 weeks as a 60-minute single IV drip infusion (≥ 30 kgs)		
		Systemic Juvenile Idiopathic Arthritis (SJIA):		
		<input type="checkbox"/> Administer 12mg/kg once every other week as a 60-minute single IV drip infusion (< 30 kgs) <input type="checkbox"/> Administer 8mg/kg once every other week as a 60-minute single IV drip infusion (≥ 30 kgs)		
<input type="checkbox"/> COSENTYX™	<input type="checkbox"/> 150mg/ml Sensoready® Pen <input type="checkbox"/> 150mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 400mg SC on day 1 and day 14	4	0
		<input type="checkbox"/> Final Induction: Inject 400mg SC on day 28, then start maintenance dose on day 42	2	0
		<input type="checkbox"/> Maintenance: Inject 200mg SC every other week	2	
		<input type="checkbox"/> Maintenance: Inject 400mg SC every 4 weeks	2	
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> 50mg/ml Sureclick® Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 50mg/ml ENBREL Mini™ with AutoTouch™ <input type="checkbox"/> 25mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/ml Lyophilized Powder Multiple Dose Vial	<input type="checkbox"/> Induction Dose: Inject 150mg SC at weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Induction Dose: Inject 300mg SC at weeks 0, 1, 2, 3, and 4	5	0
		<input type="checkbox"/> Maintenance: Inject 150mg SC every four weeks	1	
		<input type="checkbox"/> Maintenance: Inject 300mg SC every four weeks	2	
		<input type="checkbox"/> Maintenance: Inject 50mg SC once a week. Pediatric Patients: To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder > 63 kgs or more: Inject 50mg weekly < 63 kgs: Inject 0.8mg/kg weekly		
<input type="checkbox"/> HUMIRA® <input type="checkbox"/> Patient has signed HUMIRA® Complete form	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Inject 40mg SC every other week	2	
		<input type="checkbox"/> Inject 40mg SC once a week	4	
	<input type="checkbox"/> 40mg/0.4ml Pen (Citrate-Free) <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe (Citrate-Free)	<input type="checkbox"/> Inject 40mg SC every other week	2	
		<input type="checkbox"/> Inject 40mg SC once a week		

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: _____

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