Rheumatoid Arthritis
Prescription Referral Form (A to N)

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:_____

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®
- ❑ Biologics
- ❑ Calcipotriene
- ❑ Celebrex®
- ❑ Corticosteroids
- ❑ Indocin®
- ❑ Methotrexate
- ❑ 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
❑ ACTEMRA®	❑ 162mg/0.9ml Prefilled Syringe	❑ Inject 162mg SC every other week (< 100 kgs)	2	
		❑ Inject 162mg SC every week (> 100 kgs)	4	
		Polyarticular Juvenile Idiopathic Arthritis (PJIA): ❑ Inject 162mg SC every 3 weeks (< 30 kgs) ❑ Inject 162mg SC every other week (≥ 30 kgs)		
	❑ 80mg/4ml IV Single Dose Vials ❑ 200mg/10ml IV Single Dose Vials ❑ 400mg/20ml Single Dose Vials	**Polyarticular Juvenile Idiopathic Arthritis (PJIA):** ❑ Administer 10mg/kg once every 4 weeks as a 60-minute single IV drip infusion (< 30 kgs) ❑ Administer 8mg/kg once every 4 weeks as a 60-minute single IV drip infusion (≥ 30 kgs)		
		Systemic Juvenile Idiopathic Arthritis (SJIA): ❑ Administer 12mg/kg once every other week as a 60-minute single IV drip infusion (< 30 kgs) ❑ Administer 8mg/kg once every other week as a 60-minute single IV drip infusion (≥ 30 kgs		
❑ CIMZIA®	❑ Prefilled Syringe Starter Kit ❑ 200mg/ml Prefilled Syringe ❑ 200mg Lyophilized Powder Vial	❑ **Induction Dose:** Inject 400mg SC on day 1 and day 14	4	0
		❑ **Final Induction:** Inject 400mg SC on day 28, then start maintenance dose on day 42	2	0
		❑ **Maintenance:** Inject 200mg SC every other week	2	
		❑ **Maintenance:** Inject 400mg SC every 4 weeks	2	
❑ COSENTYX™	❑ 150mg/ml Sensoready® Pen ❑ 150mg/ml Prefilled Syringe	❑ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4	5	0
		❑ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4	10	0
		❑ **Maintenance:** Inject 150mg SC every four weeks	1	
		❑ **Maintenance:** Inject 300mg SC every four weeks	2	
❑ ENBREL®	❑ 50mg/ml Sureclick® Autoinjector ❑ 50mg/ml Prefilled Syringe ❑ 50mg/ml ENBREL Mini™ with AutoTouch™ ❑ 25mg/ml Prefilled Syringe ❑ 25mg/ml Lyophilized Powder Multiple Dose Vial	❑ **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		
		❑ Other: _____		
❑ HUMIRA® ❑ Patient has signed HUMIRA® Complete form	❑ 40mg/0.4ml Pen **(Citrate-Free)** ❑ 40mg/0.4ml Prefilled Syringe **(Citrate-Free)**	❑ Inject 40mg SC every other week	2	
		❑ Inject 40mg SC once a week		
❑ KEVZARA®	❑ 200mg/1.14ml Prefilled Syringe ❑ 150mg/1.14ml Prefilled Syringe	❑ Inject 200mg SC every two weeks ❑ **Reduced Dose:** Inject 150mg SC every two weeks	2	

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Dispense as written:_____ Date:_____ Substitution Permissable:_____ 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/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions:_____