Sterling SPECIALTY PHARMACY

Rheumatoid Arthritis
Prescription Referral Form (E to O)

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.

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: _____ Patient Email: _____ Caregiver Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

2 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: _____

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

❑ Provider determined the alternative treatment options would not be as effective as the prescribed medication, and therefore the requested medication is medically necessary.

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:		Drug Name:	Dates of Use:
❑ Azulfidine®	❑ Indocin®		
❑ Biologics	❑ Methotrexate		
❑ Calcipotriene	❑ Other(s):		
❑ Celebrex®			
❑ Corticosteroids			

3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
❑ 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 SQ 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: _____	❑ ___	❑ ___
		☑ **Sharps Container:** Use as directed with injectable products.	1	0
❑ HUMIRA® ❑ Patient has signed HUMIRA® Complete form	❑ 40mg/0.4ml Pen **(Citrate-Free)** ❑ 40mg/0.4ml Prefilled Syringe **(Citrate-Free)**	❑ Inject 40mg SQ every other week. ❑ Inject 40mg SQ once a week. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
		☑ **Sharps Container:** Use as directed with injectable products.	1	0
❑ KEVZARA®	❑ 200mg/1.14ml Prefilled Syringe ❑ 150mg/1.14ml Prefilled Syringe	❑ Inject 200mg SQ every two weeks. ❑ **Reduced Dose:** Inject 150mg SQ every two weeks. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
		☑ **Sharps Container:** Use as directed with injectable products.	1	0
❑ OLUMIANT®	❑ 2mg Tablet	❑ Take one 2mg tablet by mouth once a day with or without food. ❑ Other: _____	❑ 30 ❑ ___	❑ ___
❑ ORENCIA®	❑ 125mg/ml ClickJect™ Autoinjector ❑ 125mg/ml Prefilled Syringe ❑ 250mg Lyophilized Powder Vial	❑ **Induction:** Patient Weight < 60 kgs: 500mg; 60 kgs-100 kgs: 750mg; > 100 kgs: 1000mg administered IV, then inject 125 mg SQ within 24 hours. ❑ Other: _____	❑ ___	❑ ___
		❑ Inject 125mg SQ once a week. ❑ Other: _____	❑ ___	❑ ___
		☑ **Sharps Container:** Use as directed with injectable products.	1	0
❑ OTEZLA® *Only indicated for the treatment of psoriatic arthritis	❑ 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. ❑ Other: _____	❑ 55 ❑ ___	❑ ___
	❑ 30mg Tablets	❑ **Maintenance:** Take one 30mg tablet by mouth twice daily. ❑ Other: _____	❑ 60 ❑ ___	❑ ___
	❑ Bridge Rx—30mg of Otezla® (commercial insurance only)	❑ **Bridge:** Take one 30mg tablet by mouth: ❑ Twice daily (x14 days, 28 tablets, 12 refills) ❑ Once daily (x28 days, 28 tablets, 6 refills) ❑ Other: _____	❑ ___	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____

Provider Address: _____ City: _____ State: _____ Zip: _____

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

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

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.