


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: _____ **Prior Failed Treatments:** Must be completed for all patients.
 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.

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
REMICADE®	100mg Vial (5mg/kg)	Induction: Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks. Other: _____	_____	0
		Maintenance: Infuse 5mg/kg intravenously over approximately 2 hours every 6 weeks (ankylosing spondylitis). Other: _____	_____	_____
RINVOQ™	15mg Tablet	Take one 15mg tablet by mouth once daily. Other: _____	30	_____
SIMPONI®	50mg/0.5ml SmartJect® Autoinjector 50mg/0.5ml Prefilled Syringe	Inject 50mg SQ once a month in combination with methotrexate. Other: _____	_____	_____
		Sharps Container: Use as directed with injectable products.	1	0
XELJANZ® XELJANZ® XR	5mg Tablets 11mg Tablets	Take one 5mg tablet by mouth twice a day. Other: _____	60	_____
		Take one 11mg tablet by mouth once a day. Other: _____	30	_____
_____	_____	_____	_____	_____


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.
 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.