Atopic Dermatitis Prescription Referral Form

Sterling SPECIALTY PHARMACY

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www.sterlingspecialtyrx.com

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.

Primary Phone: _____ Secondary Phone: _____ Allergies: _____

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

Patient Email: _____ Caregiver Name: _____

2 Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____

3 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs & Tests with the prescription to expedite Prior Authorization.

Date of Diagnosis: _____ ICD-10: _____ Other: _____

TB Test: ❑Positive ❑Negative Date: _____ Assessment: ❑Moderate ❑Mod to Severe ❑Severe

❑Face ❑Chin ❑Neck ❑Legs ❑Hands ❑Wrists ❑Other: _____

Patient also using Topical Steroids? ❑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

Injection Training: ❑ Pharmacist to Provide ❑ Patient Trained in MD Office ❑ Manufacturer Nurse Support

If Prior Authorization is Denied: ❑Automatically Draft Appeal for Review ❑Send Preferred Formulary Alternatives

Prior Failed Treatments:	Indicate Drug Name & Length of Treatment:
❑ Topicals	
❑ Oral Meds	
❑ Biologics	
❑ Others	

4 Prescription Information

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

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dose/Strength	Direction	Qty.	Refills
❑ Dupixent®	❑ 300mg/2ml Prefilled Syringe	❑ **Induction Dose:** Inject 600mg SC on day one	2	0
		❑ **Maintenance Dose:** Inject 300mg SC every two weeks	2	
❑ Eucrisa™	❑ 2% Ointment, 60g tube	❑ Apply a thin layer twice daily on affected areas	1	
❑ _____	_____	_____		

Prescriber Signature: Prescriber, please sign and date below:

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.

# of Prescriptions: _____