



Specialty Care Program
 888.618.4126 • Fax: 866.588.0371
 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: _____
 Acute Chronic Contraindications: No Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Failed Treatments:	Indicate Drug Name & Length of Treatment:
_____	_____
_____	_____
_____	_____
_____	_____

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

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
<input type="checkbox"/> _____	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____

Prescriber Signature: Prescriber, please sign and date below:

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 only 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/MOVT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____