Atopic Dermatitis
Prescription Referral Form

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:_____

Assessment: ❑ Moderate ❑ Mod to Severe ❑ Severe

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

Patient also using Topical Steroids? ❑ Yes ❑ No Serious or active infection present ❑ Yes ❑ No

Does patient have latex allergy? ❑ Yes ❑ No

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

If Prior Authorization is Denied: Sterling will inform provider of preferred formulary alternatives and/or draft an appeal letter as advisable.

Prior Failed Treatments:	**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 Birthdate:_____

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 (**NO stamps please**):

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.

# of Prescriptions:_____