



**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: \_\_\_\_\_  
 TB Test: Positive Negative Date: \_\_\_\_\_ LFT: \_\_\_\_\_ ALT: \_\_\_\_\_ AST: \_\_\_\_\_ Date: \_\_\_\_\_  
 Assessment: Moderate Moderate to Severe Severe  
 \_\_\_\_\_ % BSA Affected Hands Scalp Feet Groin Nails

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
Biologicals	_____
Methotrexate	_____
Oral Meds	_____
Topicals	_____
UVA	_____
UVB	_____
Others	_____

Injection Training:	Yes	No
Pharmacist to Provide	_____	_____
Patient Trained in MD Office	_____	_____
Manufacturer Nurse Support	_____	_____
Patient also taking Methotrexate?	_____	_____
Serious or active infection present?	_____	_____
Hep B ruled out or treatment started?	_____	_____
Does patient have latex allergy?	_____	_____

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



**4 Prescription Information**

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

Medication	Dose/Strength	Direction	Qty.	Refills	
CIMZIA®	200mg/ml Prefilled Syringe	Psoriasis Maintenance: Inject 400mg SC every other week Other: _____	4	_____	
		Psoriatic Arthritis Induction: Inject 400mg SC at day 0, day 14, and day 28 Other: _____	6	_____	
		Psoriatic Arthritis Maintenance: Inject 400mg SC every 4 weeks Psoriatic Arthritis Maintenance: Inject 200mg SC every 2 weeks Other: _____	2	_____	
COSENTYX™	150mg/ml Sensoready® Pen 150mg/ml Prefilled Syringe	Induction: Inject 150mg SC at weeks 0, 1, 2, and 3 Induction: Inject 300mg SC at weeks 0, 1, 2, and 3 Other: _____	4 8	0	
		Maintenance: Inject 150mg SC on week 4 and every 4 weeks thereafter Maintenance: Inject 300mg SC on week 4 and every 4 weeks thereafter Other: _____	1 2	_____	
		Refill: Inject 150mg SC every 4 weeks Refill: Inject 300mg SC every 4 weeks Other: _____	1 2	_____	
ENBREL®	50mg/ml ENBREL Mini™ with AutoTouch™ 50mg/ml Sureclick® Autoinjector 50mg/ml Prefilled Syringe 25mg/ml Prefilled Syringe 25mg/ml Lyophilized Powder Multiple Dose Vial Other: _____	Induction: Inject 50mg SC twice a week (3-4 days apart) for 3 months, then start maintenance dosing Other: _____	8	2	
		Maintenance: Inject 50mg SC once a week. Pediatric Patients: To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder > 138lbs or more: Inject 50mg SC weekly < 138lbs: Inject 0.8mg/kg SC weekly Other: _____	4	_____	
HUMIRA®	Psoriasis/Uveitis Starter Package (Citrate-Free): (1) 80mg/0.8ml Pen & (2) 40mg/0.4ml Pens 40mg/0.4ml Pen (Citrate-Free) 40mg/0.4ml Prefilled Syringe (Citrate-Free)	Induction: Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week Other: _____	3	0	
		Maintenance: Inject 40mg SC every other week Other: _____	2	_____	
	Patient has signed HUMIRA® Complete form	Hidradenitis Suppurativa Starter Package (Citrate-Free): (3) 80mg/0.8ml Pens 40mg/0.4ml Pen (Citrate-Free) 40mg/0.4ml Prefilled Syringe (Citrate-Free)	Induction: Inject 160mg SC on day 1 (or 80mg on day 1 and 80mg on day 2), 80mg SC on day 15, then switch to maintenance dose on day 29 Other: _____	3	0
			Maintenance: Inject 40mg SC every week Other: _____	4	_____

**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.

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

# of Prescriptions: \_\_\_\_\_