



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	_____	_____

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
ILUMYA®	100mg/ml Solution in a Single-Dose Prefilled Syringe	Induction: Inject 100mg SC at week 0 Other: _____	1 _____	0
		Maintenance: Inject 100mg SC at week 4 and every 12 weeks thereafter Other: _____	1 _____	
ORENCIA®	125mg/ml ClickJect™ Autoinjector 125mg/ml Prefilled Syringe	Inject 125mg SC once a week Other: _____	4 _____	
OTEZLA®	Prescriber provided patient with Otezla® 2-week Starter Pack Sample Date Provided: _____		0	0
	Starter Pack (Tritration)	Starter Pack: Take one tablet by mouth in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack Other: _____	55 _____	
	30mg Tablets	Maintenance: Take one 30mg tablet by mouth twice daily Other: _____	60 _____	
	Bridge Rx—30mg of Otezla® (commercial patients only)	Bridge: Take one 30mg tablet by mouth: Twice daily (x14 days, 28 tablets, 12 refills) Once daily (x28 days, 28 tablets, 6 refills) Other: _____	_____	
REMICADE®	100mg Vial (5mg/kg)	Induction Dose: Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks Other: _____	_____	0
		Maintenance Dose: Infuse 5mg/kg intravenously over approximately 2 hours every 8 weeks Other: _____	_____	
_____	_____	_____	_____	_____

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/0H/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____