



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.

Patient Name: _____ Patient Birthdate: _____

Medication	Dose/Strength	Direction	Qty.	Refills
SILIQ™	210mg/1.5mL Prefilled Syringe	Induction: Inject the contents of 1 prefilled syringe SC at weeks 0, 1, and 2 Other: _____	3	0
		Maintenance: Inject the contents of 1 prefilled syringe SC every 2 weeks Other: _____	2	
SIMPONI®	50mg/0.5ml SmartJect® Autoinjector 50mg/0.5ml Prefilled Syringe	Inject 50mg SC once a month Other: _____	1	
		Induction: Inject the contents of 2 prefilled syringes SC at week 0 Other: _____	2	0
SKYRIZI™	75mg/mL Prefilled Syringe	Maintenance: Inject the contents of 2 prefilled syringes SC at week 4 and every 12 weeks thereafter Other: _____	2	
		Induction: Inject the contents of 1 prefilled syringe SC on day 1 Other: _____	1	0
STELARA®	45mg/0.5ml Prefilled Syringe (for < 220 lbs) 90mg/1ml Prefilled Syringe (for > 220 lbs)	Maintenance: Inject the contents of 1 prefilled syringe SC on day 29, and every 12 weeks thereafter Other: _____	1	
		Induction: Inject 160mg (2 injections) SC on day 1, then begin Induction of 80mg (1 injection) SC two weeks later (week 2) Other: _____	3	0
TALTZ®	80mg/ml Autoinjector 80mg/ml Prefilled Syringe	Induction: Inject 80mg SC on weeks 4, 6, 8, and 10 Other: _____	2	1
		Maintenance: Inject 80mg SC on week 12, and every 4 weeks thereafter Other: _____	1	0
		Refill: Inject 80mg SC every 4 weeks Other: _____	1	
TREMFYA™	100mg/ml Prefilled Syringe 100mg/ml One-Press Injector	Induction Dose: Inject 100mg SC at week 0 Other: _____	1	0
		Maintenance Dose: Inject 100mg SC at week 4 and every 8 weeks thereafter Other: _____	2	
XELJANZ® XELJANZ® XR <small>*Only indicated for the treatment of psoriatic arthritis</small>	5mg Tablet 11mg Tablet	Take one 5mg tablet by mouth twice a day Other: _____	60	
		Take one 11mg tablet by mouth once a day Other: _____	30	

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: _____