Rheumatoid Arthritis
Prescription Referral Form (O to Z)
NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

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:________

Injection Training:
- ☐ Pharmacist to Provide
- ☐ Patient Trained in MD Office
- ☐ Manufacturer Nurse Support

Patient also taking Methotrexate?	☐ Yes	☐ No
Serious or active infection present?	☐ Yes	☐ No
Hep B ruled out or treatment started?	☐ Yes	☐ No
Does patient have latex allergy?	☐ Yes	☐ No

Prior Failed Treatments:
- ☐ Azulfidine®
- ☐ Biologics
- ☐ Calcipotriene
- ☐ Celebrex®
- ☐ Corticosteroids
- ☐ Indocin®
- ☐ Methotrexate
- ☐ Other(s)

Indicate Drug Name and Length of Treatment:

____

____

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
☐ OLUMIANT®	☐ 2mg Tablet	☐ Take one 2mg tablet by mouth once a day with or without food	30	
☐ ORENCIA®	☐ 125mg/ml ClickJect™ Autoinjector ☐ 125mg/ml Prefilled Syringe ☐ 250mg Lyophilized Powder Vial	☐ **Induction:** Patient Weight < 60 kgs: 500mg; 60 kgs-100 kgs: 750mg; > 100 kgs: 1000mg administered IV, then inject 125 mg SC within 24 hours		
		☐ Inject 125mg SC once a week		
☐ OTEZLA® *Only indicated for the treatment of psoriatic arthritis	☐ Prescriber provided patient with Otezla® 2 week Starter Pack Sample	**Date Provided:** ____/____/______	0	0
	☐ Starter Pack (Titration)	☐ **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	55	
	☐ 30mg Tablets	☐ **Maintenance:** Take one 30mg tablet by mouth twice daily	60	
	☐ Bridge Rx—30mg of Otezla® (commercial insurance only)	☐ **Bridge:** Take one 30mg tablet by mouth: ☐ Twice daily (x14 days, 28 tablets, 12 refills) ☐ Once daily (x28 days, 28 tablets, 6 refills)		
☐ REMICADE®	☐ 100mg Vial (5mg/kg)	☐ **Induction:** Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks		0
		☐ **Maintenance:** Infuse 5mg/kg intravenously over approximately 2 hours every 6 weeks (ankylosing spondylitis)		
☐ SIMPONI®	☐ 50mg/0.5ml SmartJect® Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg SC once a month in combination with methotrexate		
☐ STELARA® *Only indicated for the treatment of psoriatic arthritis	☐ 45mg/0.5ml Prefilled Syringe (for < 220 lbs) ☐ 90mg/1ml Prefilled Syringe (> 220 lbs)	☐ **Induction:** Inject 1 prefilled syringe SC on day 1		
		☐ **Maintenance:** Inject 1 prefilled syringe SC on day 29, and every 12 weeks thereafter		
☐ TALTZ® *Only indicated for the treatment of psoriatic arthritis	☐ 80mg/ml Autoinjector ☐ 80mg/ml Prefilled Syringe	☐ **Starting dose:** Inject 160mg (2 injections) SC on day 1, then begin Maintenance dose 4 weeks later	2	
		☐ **Maintenance:** Inject 80mg SC every 4 weeks	1	
☐ XELJANZ® ☐ XELJANZ® XR	☐ 5mg Tablets ☐ 11mg Tablets	☐ Take one 5mg tablet by mouth twice a day	60	
		☐ Take one 11mg tablet by mouth once a day	30	

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Dispense as written:____________ Date:________ Substitution Permissable:____________ 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/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions:________

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