Ancillary Immunology
Prescription Referral Form

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.

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: _____ Patient Email: _____ Caregiver Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

2 Diagnosis/Clinical Information

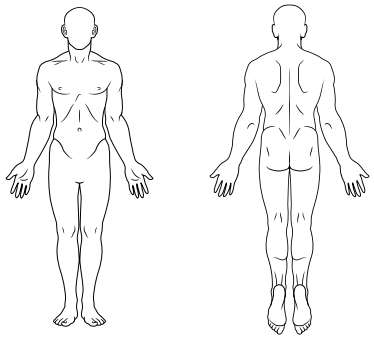
Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
❑ Methotrexate	❑ _____	❑	_____
❑ Rasuvo	❑ _____	❑	_____
❑ Otrexup	❑ _____	❑	_____
❑ Clobetasol	❑ _____	❑	_____
❑ Hydrocortisone	❑ _____	❑	_____
❑ Naproxen/Aleve	❑ _____	❑	_____
❑ _____	❑ _____	❑	_____
❑ _____	❑ _____	❑	_____

Phototherapy:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
❑ UVA/UVB	❑ _____	❑	_____

❑ Patient Cannot Afford ❑ Photosensitivity ❑ Risk of Skin Cancer ❑ Distance from Office

❑ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
❑ M06.9 Rheumatoid Arthritis, Unspecified
❑ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
❑ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
❑ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
❑ Other: _____



❑ Face ❑ Feet ❑ Groin ❑ Hands
❑ Nails ❑ Scalp ❑ Other: _____

Scoring Tool Used:
❑ BSA ❑ EASI ❑ ISGA ❑ POEM
❑ SCORAD _____% or Score: _____

Active TB is Ruled Out: ❑ Yes ❑ No Date: _____
Hep B Ruled Out/Treated: ❑ Yes ❑ No Date: _____

Date of Diagnosis: _____

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
❑ OTREXUP®	❑ 10mg Auto Injector ❑ 20mg Auto Injector ❑ 12.5mg Auto Injector ❑ 22.5mg Auto Injector ❑ 15mg Auto Injector ❑ 25mg Auto Injector ❑ 17.5mg Auto Injector	❑ Inject SQ every week. ❑ Other: _____	❑ 4 ❑ ___	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____

Provider Address: _____ City: _____ State: _____ Zip: _____

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.