Sterling SPECIALTY PHARMACY

Antipsychotic
Prescription Referral Form (A to N)

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.

Diagnosis/ICD-10: _____ Diagnosis Date: _____ Other: _____

❑ Acute ❑ Chronic Contraindications: ❑ No ❑ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
❑		
❑		
❑		
❑		
❑		

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
❑ ABILIFY MAINTENA®	❑ 300mg Prefilled Syringe ❑ 400mg Prefilled Syringe	❑ Inject IM once monthly. ❑ Other: _____	❑ 1 ❑ ___	❑ ___
❑ ARISTADA®	❑ 441mg Prefilled Syringe ❑ 662mg Prefilled Syringe ❑ 882mg Prefilled Syringe ❑ 1064mg Prefilled Syringe	❑ Inject IM every 4 weeks. ❑ Inject IM every 6 weeks. ❑ Inject IM every 8 weeks. ❑ Other: _____	❑ 1 ❑ ___	❑ ___
❑ AUSTEDO®	❑ 6mg Tablet ❑ 9mg Tablet ❑ 12mg Tablet	❑ Other: _____	❑ ___	❑ ___
❑ INVEGA SUSTENNA®	❑ 39mg Prefilled Syringe ❑ 78mg Prefilled Syringe ❑ 117mg Prefilled Syringe ❑ 156mg Prefilled Syringe ❑ 234mg Prefilled Syringe	❑ **Induction Dose:** Inject 234mg IM on day 1 followed by 156mg 1 week later, then switch to maintenance dose. ❑ **Maintenance Dose:** Inject IM once monthly. ❑ Other: _____	❑ 1 ❑ ___	❑ ___
❑ INVEGA TRINZA®	❑ 273mg Prefilled Syringe ❑ 410mg Prefilled Syringe ❑ 546mg Prefilled Syringe ❑ 819mg Prefilled Syringe	❑ Inject IM every 3 months. ❑ Other: _____	❑ 1 ❑ ___	❑ ___
❑ LATUDA®	❑ 20mg Tablet ❑ 40mg Tablet ❑ 60mg Tablet ❑ 80mg Tablet ❑ 120mg Tablet	❑ Take one tablet by mouth once daily. ❑ Other: _____	❑ 30 ❑ ___	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

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.