



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: _____

Prior Failed Treatments: Must be completed for all patients.

Acute Chronic Contraindications: No Yes _____

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

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

Test/Procedure: _____ Date Performed: _____ Results: _____

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
PERSERIS™	90mg Prefilled Syringe 120mg Prefilled Syringe	Inject SQ once monthly. Other: _____	1 ____	____
RISPERDAL CONSTA IM®	12.5mg Prefilled Syringe 25mg Prefilled Syringe 37.5mg Prefilled Syringe 50mg Prefilled Syringe	Inject IM every 2 weeks. Other: _____	2 ____	____
RISPERDAL CONSTA SQ®	90mg Prefilled Syringe 120mg Prefilled Syringe	Inject SQ once monthly. Other: _____	1 ____	____
VIVITROL®	380mg Vial Kit	Inject 380mg IM every 4 weeks. Other: _____	1 ____	____
VRAYLAR®	1.5mg Capsule 3mg Capsule 4.5mg Capsule 6mg Capsule	Other: _____	____	____
ZYPREXA RELPREV®	210mg Kit 300mg Kit 405mg Kit	Inject IM every 2 weeks. Other: _____	2 ____	____
		Inject IM every 4 weeks. Other: _____	1 ____	____
_____	_____	_____	____	____

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