Sterling SPECIALTY PHARMACY

Atopic Dermatitis
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.

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

Assessment: ❑ Moderate ❑ Moderate to Severe ❑ Severe

_____% BSA Affected BSA Scoring Tool Name: _____

❑ Face ❑ Hands ❑ Neck ❑ Legs ❑ Chin ❑ Wrists ❑ Other: _____

Patient also using topical steroids? ❑ Yes ❑ No Serious or active infection present? ❑ Yes ❑ No

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
❑ Topicals		
❑ Oral Meds		
❑ Biologics		
❑ Other:		

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
❑ DUPIXENT®	❑ 300mg/2ml Prefilled Syringe	❑ **Induction Dose:** Inject 600mg SQ on day one. ❑ Other: _____	❑ 2 ❑ ___	0
		❑ **Maintenance Dose:** Inject 300mg SQ every two weeks. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
❑ EUCRISA™	❑ 2% Ointment, 60g Tube	❑ Apply a thin layer twice daily on affected areas. ❑ 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**):

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

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.

© 2020 SterlingRx, Inc. dba Sterling Specialty Pharmacy. All rights reserved. 900.03.00-2020-10-15