



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
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**):

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.