



Date Medication Needed: _____ Ship to: Patient's Home Prescriber's Office Pharmacy to Coordinate



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: _____ Secondary Phone: _____ Patient Email: _____ Caregiver Name: _____
 Patient Address: _____ City: _____ State: _____ Zip: _____



2 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____ DEA#: _____ NPI#: _____
 Provider Address: _____ City: _____ State: _____ Zip: _____
 Key Contact: _____ Phone: _____ Fax: _____ Email: _____



3 Diagnosis/Clinical Information

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

Diagnosis/ICD-10: _____ Diagnosis Date: _____ Other: _____
 BMI: _____ BMI Date: _____
 Associated Medical Conditions: _____
 Injection Training: Pharmacist to Provide Patient Trained in MD Office

Prior Failed Treatments: Drug Name & Length of Treatment:

_____	_____
_____	_____
_____	_____

If Prior Authorization is Denied: Sterling will inform provider of preferred formulary alternatives and/or draft an appeal letter as advisable.



4 Prescription Information

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

Patient Name: _____ Patient Birthdate: _____

Medication	Dose/Strength	Direction	Qty.	Refills
SAXENDA®	18mg/3ml Pen	Induction: Inject 0.6mg SC once daily for one week, then increase by 0.6mg daily at weekly intervals to a target dose of 3mg once daily Other: _____	5	_____
		Maintenance: Inject 3mg SC once daily Other: _____	5	_____
PEN NEEDLE	4mm/32g Needle	Use for Saxenda injections once daily	100	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

of Prescriptions: _____