



Sterling
SPECIALTY PHARMACY

Gastrointestinal Disease
Prescription Referral Form (A to R)

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: _____

TB Test: Positive Negative Date: _____

Hep B ruled out or treatment started? Yes No

Crohn's Disease Ulcerative Colitis Irritable Bowel Syndrome

Serious or active infection present? Yes No

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
5-ASA	_____	_____
Biologics	_____	_____
Corticosteroids	_____	_____
Immunosuppressants	_____	_____
Methotrexate	_____	_____
Surgery	_____	_____
Other: _____	_____	_____



3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
CIMZIA®	Prefilled Syringe Starter Kit	Induction Dose: Inject 400mg SQ on day 1, day 14, and day 28. Other: _____	6	0
	200mg/ml Prefilled Syringe 200mg Lyophilized Powder Vial	Maintenance: Inject 400mg SQ every 4 weeks. Other: _____	2	_____
ENTYVIO®	300mg Vial	Induction Dose: Infuse 300mg intravenously over approximately 30 minutes at 0, 2, and 6 weeks. Other: _____	3	0
		Maintenance: Infuse 300mg intravenously over approximately 30 minutes every 8 weeks. Other: _____	1	_____
HUMIRA® Patient has signed HUMIRA® Complete form	Crohn's Disease/Uveitis Starter Package (Citrate-Free)	Induction: Inject 160mg SQ on day 1, then 80mg SQ on day 15, then 40mg SQ every other week. Other: _____	3	0
	40mg/0.4ml Pen (Citrate-Free) 40mg/0.4ml Prefilled Syringe (Citrate-Free)	Maintenance: Inject 40mg SQ every other week. Other: _____	2	_____
REMICADE®	100mg Vial (5mg/kg)	Induction Dose: Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks. Other: _____	_____	0
		Maintenance Dose: Infuse 5mg/kg intravenously over approximately 2 hours every 8 weeks. Other: _____	_____	_____
_____	_____	_____	_____	_____



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.

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