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		
❑ Immunosuppresants		
❑ 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**):

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.