Sterling SPECIALTY PHARMACY

Gastrointestinal Disease
Prescription Referral Form (S to Z)

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
❑ SIMPONI®	❑ 100mg/ml SmartJect® Autoinjector	❑ **Induction Dose:** Inject 200mg SQ at week 0, then 100mg SQ at week 2, and then switch to maintenance dose. ❑ Other: _____	❑ 3 ❑ ___	❑ 0 ❑ ___
	❑ 100mg/ml Prefilled Syringe	❑ **Maintenance:** Inject 100mg SQ every 4 weeks. ❑ Other: _____	❑ 1 ❑ ___	❑ ___
❑ STELARA®	❑ 130mg/26ml Vial	❑ **Induction Dose:** Patient weight, <55kg: 260mg; >55kg to 85kg: 390mg; >85kg: 520mg administered IV. ❑ Other: _____	❑ ___	❑ 0 ❑ ___
	❑ 90mg/ml Prefilled Syringe	❑ **Maintenance:** Inject 90mg SQ 8 weeks after initial IV dose, then every 8 weeks thereafter. ❑ Other: _____	❑ 1 ❑ ___	❑ ___
❑ UCERIS®	❑ 9mg Tablets	❑ Take one tablet daily in the morning with or without food. ❑ Other: _____	❑ 30 ❑ ___	❑ 1 ❑ ___
❑ XELJANZ®	❑ 5mg Tablets ❑ 10mg Tablets	❑ Take one 10mg tablet by mouth twice a day with or without food for the first 8 weeks. ❑ Take one 5mg tablet by mouth twice a day with or without food. ❑ Take one 10mg tablet by mouth twice a day with or without food. ❑ Other: _____	❑ 60 ❑ ___	❑ ___
❑ XIFAXAN®	❑ 550mg Tablets	❑ Take one tablet three times daily for 14 days. ❑ Other: _____	❑ 42 ❑ ___	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

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.