


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
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):

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.