



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.

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: _____
 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

Injection Training:

- Pharmacist to Provide
- Patient Trained in MD Office
- Manufacturer Nurse Support

Prior Failed Treatments:

- 5-ASA _____
- Biologics _____
- Corticosteroids _____
- Immunosuppressants _____
- Methotrexate _____
- Surgery _____
- Others _____

Indicate Drug Name and 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
<input type="checkbox"/> REMICADE®	<input type="checkbox"/> 100mg Vial (5mg/kg)	<input type="checkbox"/> Induction Dose: Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks		0
		<input type="checkbox"/> Maintenance Dose: Infuse 5mg/kg intravenously over approximately 2 hours every 8 weeks		
<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> 100mg/ml SmartJect® Autoinjector	<input type="checkbox"/> Induction Dose: Inject 200mg SC at week 0, then 100mg SC at week 2, and then switch to maintenance dose	3	0
	<input type="checkbox"/> 100mg/ml Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject 100mg SC every 4 weeks	1	
<input type="checkbox"/> STELARA®	<input type="checkbox"/> 130mg/26ml Vial	<input type="checkbox"/> Induction Dose: Patient weight, <55kg: 260mg; >55kg to 85kg: 390mg; >85kg: 520mg administered IV		0
	<input type="checkbox"/> 90mg/ml Prefilled Syringe	<input type="checkbox"/> Maintenance: Inject 90mg SC 8 weeks after initial IV dose, then every 8 weeks thereafter	1	
<input type="checkbox"/> UCERIS®	<input type="checkbox"/> 9mg Tablets	<input type="checkbox"/> Take one tablet daily in the morning with or without food	30	1
<input type="checkbox"/> XIFAXAN®	<input type="checkbox"/> 550mg Tablets	<input type="checkbox"/> Take one tablet three times daily for 14 days	42	
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> 5mg Tablets	<input type="checkbox"/> Take one 10mg tablet by mouth twice a day (with or without food) for the first 8 weeks	60	
	<input type="checkbox"/> 10mg Tablets	<input type="checkbox"/> Take one 5mg tablet by mouth twice a day with, or without, food <input type="checkbox"/> Take one 10 mg tablet by mouth twice a day with, or without, food		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

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: _____