Sterling SPECIALTY PHARMACY

Psoriasis
Prescription Referral Form (A to H)

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: _____ LFT: _____ ALT: _____ AST: _____ Date: _____

Assessment: ❑ Moderate ❑ Moderate to Severe ❑ Severe

_____% BSA Affected BSA Scoring Tool Name: _____

❑ Hands ❑ Scalp ❑ Feet ❑ Groin ❑ Nails ❑ Other: _____

Patient also taking Methotrexate?	❑ Yes	❑ No
Serious or active infection present?	❑ Yes	❑ No
Hep B ruled out or treatment started?	❑ Yes	❑ No
Does patient have latex allergy?	❑ Yes	❑ No

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
❑ Biologicals		
❑ Methotrexate		
❑ Oral Meds		
❑ Topicals		
❑ UVA		
❑ UVB		
❑ Other:		

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
❑ CIMZIA®	❑ 200mg/ml Prefilled Syringe	❑ **Psoriasis Maintenance:** Inject 400mg SQ every other week. ❑ Other: _____	❑ 4 ❑ ___	❑ ___
		❑ **Psoriatic Arthritis Induction:** Inject 400mg SQ at day 0, day 14, and day 28. ❑ Other: _____	❑ 6 ❑ ___	❑ ___
		❑ **Psoriatic Arthritis Maintenance:** Inject 400mg SQ every 4 weeks. ❑ **Psoriatic Arthritis Maintenance:** Inject 200mg SQ every 2 weeks. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
❑ COSENTYX™	❑ 150mg/ml Sensoready® Pen ❑ 150mg/ml Prefilled Syringe	❑ **Induction:** Inject 150mg SQ at weeks 0, 1, 2, and 3. ❑ **Induction:** Inject 300mg SQ at weeks 0, 1, 2, and 3. ❑ Other: _____	❑ 4 ❑ 8 ❑ ___	❑ 0 ❑ ___
		❑ **Maintenance:** Inject 150mg SQ on week 4 and every 4 weeks thereafter. ❑ **Maintenance:** Inject 300mg SQ on week 4 and every 4 weeks thereafter. ❑ Other: _____	❑ 1 ❑ 2 ❑ ___	❑ ___
		❑ **Refill:** Inject 150mg SQ every 4 weeks. ❑ **Refill:** Inject 300mg SQ every 4 weeks. ❑ Other: _____	❑ 1 ❑ 2 ❑ ___	❑ ___
❑ ENBREL®	❑ 50mg/ml ENBREL Mini™ with AutoTouch™ ❑ 50mg/ml Sureclick® Autoinjector ❑ 50mg/ml Prefilled Syringe ❑ 25mg/ml Prefilled Syringe ❑ 25mg/ml Lyophilized Powder Multiple Dose Vial ❑ Other: _____	❑ **Induction:** Inject 50mg SQ twice a week (3-4 days apart) for 3 months, then start maintenance dosing. ❑ Other: _____	❑ 8 ❑ ___	❑ 2 ❑ ___
		❑ **Maintenance:** Inject 50mg SQ once a week. **Pediatric Patients:** To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder. ❑ > 138lbs or more: Inject 50mg SQ weekly. ❑ < 138lbs: Inject 0.8mg/kg SQ weekly. ❑ Other: _____	❑ 4 ❑ ___	❑ ___
❑ HUMIRA® ❑ Patient has signed HUMIRA® Complete form	❑ Psoriasis/Uveitis Starter Package **(Citrate-Free)**: (1) 80mg/0.8ml Pen & (2) 40mg/0.4ml Pens ❑ 40mg/0.4ml Pen **(Citrate-Free)** ❑ 40mg/0.4ml Prefilled Syringe **(Citrate-Free)**	❑ **Induction:** Inject 80mg SQ on day 1, then 40mg SQ on day 8, then 40mg SQ every other week. ❑ Other: _____	❑ 3 ❑ ___	❑ 0 ❑ ___
		❑ **Maintenance:** Inject 40mg SQ every other week. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
	❑ Hidradenitis Suppurativa Starter Package **(Citrate-Free):** (3) 80mg/0.8ml Pens ❑ 40mg/0.4ml Pen **(Citrate-Free)** ❑ 40mg/0.4ml Prefilled Syringe **(Citrate-Free)**	❑ **Induction:** Inject 160mg SQ on day 1 (or 80mg on day 1 and 80mg on day 2), 80mg SQ on day 15, then switch to maintenance dose on day 29. ❑ Other: _____	❑ 3 ❑ ___	❑ 0 ❑ ___
		❑ **Maintenance:** Inject 40mg SQ every week. ❑ Other: _____	❑ 4 ❑ ___	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

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.