

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: _____

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
Biologics	_____	_____
Methotrexate	_____	_____
Oral Meds	_____	_____
Topicals	_____	_____
UVA	_____	_____
UVB	_____	_____
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

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills	
CIMZIA®	Cimzia Starter Package: (2) 200mg/ml Prefilled Syringe	Induction: Inject 400mg SQ on weeks 0, 2, and 4. Other: _____	6	0	
	200mg/ml Prefilled Syringe	Maintenance: Inject 200mg SQ every other week. Maintenance: Inject 400mg SQ every other week. Other: _____	2 4		
		Sharps Container: Use as directed with injectable products. (Qty: 1)	_____	_____	
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		
		Sharps Container: Use as directed with injectable products. (Qty: 1)	_____	_____	
		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		
		Sharps Container: Use as directed with injectable products. (Qty: 1)	_____	_____	
HUMIRA®	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		
	Patient has signed HUMIRA® Complete form	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	
		Sharps Container: Use as directed with injectable products. (Qty: 1)	_____	_____	

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/DH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.