Sterling SPECIALTY PHARMACY

Psoriasis
Prescription Referral Form (I to R)

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
❑ ILUMYA®	❑ 100mg/ml Solution in a Single-Dose Prefilled Syringe	❑ **Induction:** Inject 100mg SQ at week 0. ❑ Other: _____	❑ 1 ❑ ___	❑ 0 ❑ ___
		❑ **Maintenance:** Inject 100mg SQ at week 4 and every 12 weeks thereafter. ❑ Other: _____	❑ 1 ❑ ___	❑ ___
❑ ORENCIA®	❑ 125mg/ml ClickJect™ Autoinjector ❑ 125mg/ml Prefilled Syringe	❑ Inject 125mg SQ once a week. ❑ Other: _____	❑ 4 ❑ ___	❑ ___
❑ OTEZLA®	❑ Prescriber provided patient with Otezla® 2-week Starter Pack Sample. **Date Provided:** _____		0	0
	❑ Starter Pack (Tritration)	❑ **Starter Pack:** Take one tablet by mouth in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack. ❑ Other: _____	❑ 55 ❑ ___	❑ ___
	❑ 30mg Tablets	❑ **Maintenance:** Take one 30mg tablet by mouth twice daily. ❑ Other: _____	❑ 60 ❑ ___	❑ ___
❑ OTREXUP®	❑ 10mg/0.4ml Autoinjector ❑ 12.5mg/0.4ml Autoinjector ❑ 15mg/0.4ml Autoinjector ❑ 17.5mg/0.4ml Autoinjector ❑ 20mg/0.4ml Autoinjector ❑ 22.5mg/0.4ml Autoinjector ❑ 25mg/0.4ml Autoinjector	❑ Inject SQ every week. ❑ Other: _____	❑ 4 ❑ ___	❑ ___
❑ REMICADE®	❑ 100mg Vial (5mg/kg)	❑ **Induction Dose:** Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks. ❑ Other: _____	❑ ___	❑ 0 ❑ ___
		❑ **Maintenance Dose:** Infuse 5mg/kg intravenously over approximately 2 hours every 8 weeks. ❑ Other: _____	❑ ___	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

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.