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.

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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**):

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.