



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
SILIQ™	210mg/1.5mL Prefilled Syringe	Induction: Inject the contents of 1 prefilled syringe SQ at weeks 0, 1, and 2. Other: _____	3	0
		Maintenance: Inject the contents of 1 prefilled syringe SQ every 2 weeks. Other: _____	2	_____
SIMPONI®	50mg/0.5ml SmartJect® Autoinjector 50mg/0.5ml Prefilled Syringe	Inject 50mg SQ once a month. Other: _____	1	_____
SKYRIZI™	75mg/mL Prefilled Syringe	Induction: Inject the contents of 2 prefilled syringes SQ at week 0. Other: _____	2	0
		Maintenance: Inject the contents of 2 prefilled syringes SQ at week 4 and every 12 weeks thereafter. Other: _____	2	_____
STELARA®	45mg/0.5ml Prefilled Syringe (for < 220 lbs) 90mg/1ml Prefilled Syringe (for > 220 lbs)	Induction: Inject the contents of 1 prefilled syringe SQ on day 1. Other: _____	1	0
		Maintenance: Inject the contents of 1 prefilled syringe SQ on day 29, and every 12 weeks thereafter. Other: _____	1	_____
TALTZ®	80mg/ml Autoinjector 80mg/ml Prefilled Syringe	Starting dose: Inject 160mg (2 injections) SQ on day 1, then begin Induction of 80mg (1 injection) SQ two weeks later (week 2). Other: _____	3	0
		Induction: Inject 80mg SQ on weeks 4, 6, 8, and 10. Other: _____	2	1
		Maintenance: Inject 80mg SQ on week 12, and every 4 weeks thereafter. Other: _____	1	0
		Refill: Inject 80mg SQ every 4 weeks. Other: _____	1	_____
TREMFYA™	100mg/ml Prefilled Syringe 100mg/ml One-Press Injector	Induction Dose: Inject 100mg SQ at week 0. Other: _____	1	0
		Maintenance Dose: Inject 100mg SQ at week 4 and every 8 weeks thereafter. Other: _____	2	_____
_____	_____	_____	_____	_____

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.