


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: _____

Injection Training:

 Pharmacist to Provide
 Patient Trained in MD Office
 Manufacturer Nurse Support

 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:

 Azulfidine® Indocin®
 Biologics Methotrexate
 Calcipotriene Other(s)
 Celebrex®
 Corticosteroids

Drug Name & Length of Treatment:



3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
ACTEMRA®	162mg/0.9ml Prefilled Syringe	Inject 162mg SC every other week (< 100 kgs) Other: _____	2	
		Inject 162mg SC every week (> 100 kgs) Other: _____	4	
	80mg/4ml IV Single Dose Vials 200mg/10ml IV Single Dose Vials 400mg/20ml Single Dose Vials	Polyarticular Juvenile Idiopathic Arthritis (PJIA): Inject 162mg SC every 3 weeks (< 30 kgs) Inject 162mg SC every other week (≥ 30 kgs) Other: _____	—	
		Polyarticular Juvenile Idiopathic Arthritis (PJIA): Administer 10mg/kg once every 4 weeks as a 60-minute single IV drip infusion (< 30 kgs) Administer 8mg/kg once every 4 weeks as a 60-minute single IV drip infusion (≥ 30 kgs) Other: _____	—	
CIMZIA®	Prefilled Syringe Starter Kit 200mg/ml Prefilled Syringe 200mg Lyophilized Powder Vial	Induction Dose: Inject 400mg SC on day 1 and day 14 Other: _____	4	0
		Final Induction: Inject 400mg SC on day 28, then start maintenance dose on day 42 Other: _____	2	0
		Maintenance: Inject 200mg SC every other week Maintenance: Inject 400mg SC every 4 weeks Other: _____	2	—
COSENTYX™	150mg/ml Sensoready® Pen 150mg/ml Prefilled Syringe	Induction Dose: Inject 150mg SC at weeks 0, 1, 2, 3, and 4 Induction Dose: Inject 300mg SC at weeks 0, 1, 2, 3, and 4 Other: _____	5 10	0
		Maintenance: Inject 150mg SC every four weeks Maintenance: Inject 300mg SC every four weeks Other: _____	1 2	—
ENBREL®	50mg/ml Sureclick® Autoinjector 50mg/ml Prefilled Syringe 50mg/ml ENBREL Mini™ with AutoTouch™ 25mg/ml Prefilled Syringe 25mg/ml Lyophilized Powder Multiple Dose Vial	Maintenance: Inject 50mg SC once a week. Pediatric Patients: To achieve pediatric doses other than 50mg or 25mg, use reconstituted Enbrel lyophilized powder > 63 kgs or more: Inject 50mg weekly < 63 kgs: Inject 0.8mg/kg weekly Other: _____	—	—


4 Provider/Prescriber Information

 Clinic Name: _____ Provider Name: _____
 Provider Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____ DEA#: _____ NPI#: _____


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.
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