Sterling SPECIALTY PHARMACY

Rheumatoid Arthritis
Prescription Referral Form (A to G)

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: _____

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

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 SQ every other week (< 100 kgs). ❑ Other: _____	❑ 2 ❑ ___	❑ ___
		❑ Inject 162mg SQ every week (> 100 kgs). ❑ Other: _____	❑ 4 ❑ ___	❑ ___
		Polyarticular Juvenile Idiopathic Arthritis (PJIA): ❑ Inject 162mg SQ every 3 weeks (< 30 kgs). ❑ Inject 162mg SQ every other week (≥ 30 kgs). ❑ Other: _____	❑ ___	❑ ___
	❑ 80mg/4ml IV Single Dose Vials ❑ 200mg/10ml IV Single Dose Vials ❑ 400mg/20ml Single Dose Vials	**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: _____	❑ ___	❑ ___
		Systemic Juvenile Idiopathic Arthritis (SJIA): ❑ Administer 12mg/kg once every other week as a 60-minute single IV drip infusion (< 30 kgs). ❑ Administer 8mg/kg once every other week 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 SQ on day 1 and day 14. ❑ Other: _____	❑ 4 ❑ ___	❑ 0 ❑ ___
		❑ **Final Induction:** Inject 400mg SQ on day 28, then start maintenance dose on day 42. ❑ Other: _____	❑ 2 ❑ ___	❑ 0 ❑ ___
		❑ **Maintenance:** Inject 200mg SQ every other week. ❑ **Maintenance:** Inject 400mg SQ every 4 weeks. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
❑ COSENTYX™	❑ 150mg/ml Sensoready® Pen ❑ 150mg/ml Prefilled Syringe	❑ **Induction Dose:** Inject 150mg SQ at weeks 0, 1, 2, 3, and 4. ❑ **Induction Dose:** Inject 300mg SQ at weeks 0, 1, 2, 3, and 4. ❑ Other: _____	❑ 5 ❑ 10 ❑ ___	❑ 0 ❑ ___
		❑ **Maintenance:** Inject 150mg SQ every four weeks. ❑ **Maintenance:** Inject 300mg SQ 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 SQ 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 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.