


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	_____
	80mg/4ml IV Single Dose Vials 200mg/10ml IV Single Dose Vials 400mg/20ml Single Dose Vials	Polyarticular Juvenile Idiopathic Arthritis (PJIA): Inject 162mg SQ every 3 weeks (< 30 kgs). Inject 162mg SQ every other week (≥ 30 kgs). Other: _____	_____	_____
		Polyarticular Juvenile Idiopathic Arthritis (PJIA): Administer 12mg/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 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):

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.