Sterling SPECIALTY PHARMACY

Rheumatoid Arthritis
Prescription Referral Form (P to Z)

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: _____

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

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
❑ REMICADE®	❑ 100mg Vial (5mg/kg)	❑ **Induction:** Infuse 5mg/kg intravenously over approximately 2 hours at 0, 2, and 6 weeks ❑ Other: _____	❑ ___	0
		❑ **Maintenance:** Infuse 5mg/kg intravenously over approximately 2 hours every 6 weeks (ankylosing spondylitis) ❑ Other: _____	❑ ___	
❑ RINVOQ™	❑ 15mg Tablet	❑ Take one 15mg tablet by mouth once daily ❑ Other: _____	❑ 30 ❑ ___	
❑ SIMPONI®	❑ 50mg/0.5ml SmartJect® Autoinjector ❑ 50mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC once a month in combination with methotrexate ❑ Other: _____	❑ ___	
❑ STELARA® *Only indicated for the treatment of psoriatic arthritis	❑ 45mg/0.5ml Prefilled Syringe (for < 220 lbs) ❑ 90mg/1ml Prefilled Syringe (> 220 lbs)	❑ **Induction:** Inject 1 prefilled syringe SC on day 1 ❑ Other: _____	❑ ___	
		❑ **Maintenance:** Inject 1 prefilled syringe SC on day 29, and every 12 weeks thereafter ❑ Other: _____	❑ ___	
❑ TALTZ® *Only indicated for the treatment of psoriatic arthritis	❑ 80mg/ml Autoinjector ❑ 80mg/ml Prefilled Syringe	❑ **Starting dose:** Inject 160mg (2 injections) SC on day 1, then begin Maintenance dose 4 weeks later ❑ Other: _____	❑ 2 ❑ ___	
		❑ **Maintenance:** Inject 80mg SC every 4 weeks ❑ Other: _____	❑ 1 ❑ ___	
❑ XELJANZ® ❑ XELJANZ® XR	❑ 5mg Tablets ❑ 11mg Tablets	❑ Take one 5mg tablet by mouth twice a day ❑ Other: _____	❑ 60 ❑ ___	
		❑ Take one 11mg tablet by mouth once a day ❑ Other: _____	❑ 30 ❑ ___	
❑ _____	❑ _____	❑ _____	❑ ___	

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.