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: _____

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
❑ 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 SQ once a month in combination with methotrexate. ❑ Other: _____	❑ ___	❑ ___
❑ 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 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.