



Sterling
SPECIALTY PHARMACY

**Severe Hypoglycemia
Prescription Referral Form**

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.

Check all that apply. Be sure to complete the information on the right-hand side.

Diagnosis:

- Type 1 E10.649
- Type 2 E11.649
- Other: _____

Additional Clinical Rational for Treatment—Patient Has:

- History of prior severe hypoglycemia
- Prior history of failure to correctly administer convectional kits (lack of dexterity, unable to open, poor vision/cannot read instructions, poor memory, become agitated/panicked, low health literacy)
- ER visits/hospitalizations
- Impairments
- Co-morbidities
- Additional rational: _____

Previously Tried & Failed Treatments: Must be completed for all patients.

Treatments Include:

- Glucagon Emergency Kit
- Glucagon HypoKit
- Zegalogue
- Baqsimi
- Other: _____



3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
GVOKE HYOPEN®	Gvoke HypoPen 2-Pack™ 0.5mg/0.1mL Gvoke HypoPen 2-Pack™ 1.0mg/0.2mL	Dose: Inject SQ during a severe hypoglycemic event as needed. Other: _____	2 Pens	___
GVOKE® PFS	Gvoke PFS 2-Pack™ 0.5mg/0.1mL Gvoke PFS 2-Pack™ 1mg/0.2mL	Dose: Inject SQ during a severe hypoglycemic event as needed. Other: _____	2 Pens	___
_____	_____	_____	___	___



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/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.