



**Sterling**  
SPECIALTY PHARMACY

**General Dermatology**  
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.

Diagnosis/ICD-10: \_\_\_\_\_ Diagnosis Date: \_\_\_\_\_ Other: \_\_\_\_\_

Acute Chronic

Contraindications: No Yes \_\_\_\_\_

**Prior Failed Treatments:** Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
_____	_____	_____
_____	_____	_____
_____	_____	_____



**3 Prescription Information**

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

Medication	Dose/Strength	Direction	Qty.	Refills
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



**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.