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
- ❑ GlucaGen HypoKit
- ❑ Zegalogue
- ❑ Baqsimi
- ❑ Other: _____

❑ Provider has determined that the alternative treatment options would not be as effective as the prescribed medication, and therefore the requested medication is medically necessary.

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
❑ GVOKE HYPOPEN®	❑ 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	❑ ___
❑ GVOKE® KIT	❑ Gvoke Kit™ 1mg/0.2mL	❑ **Dose:** Inject SQ during a severe hypoglycemic event as needed. ❑ Other: _____	❑ 1 Kit	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

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.