Sterling SPECIALTY PHARMACY

Urology
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: _____

How many voids per night for the last 6 months? _____

Have lifestyle changes been made to avoid nocturia: ❑ Yes ❑ No

Has the patient had any of the following in the last 6 months:

❑ Renal Impairment (eFGR less than 50mL/min) ❑ Uncontrolled Hypertension ❑ Polydipsia
❑ Hyponatremia or History of Hyponatremia ❑ Uncontrolled Diabetes Mellitus ❑ Nocturnal Enuresis
❑ Chronic Prostatitis/Pelvic Pain Syndrome ❑ Interstitial Cystitis ❑ SIADH
❑ Bladder Outlet Obstruction (BOO) ❑ Congestive Heart Failure

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
24-Hour Urine Collection		
Serum Sodium		

Prior Failed Treatments: Must be completed for all patients.

Treatment Type	Drug Name	Dates of Use
❑ DDAVP Tablet		
❑ Diuretics		
❑		
❑		
❑		

Black Box Warning:

☑ Patient and prescriber are aware of Black Box Warning, and prescriber views the benefits to outweigh the risks.

❑ 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
❑ NOCDURNA®	❑ 27.7mcg (Female) ❑ 55.3mcg (Male)	❑ Dissolve 1 tablet under tongue every night at bedtime. ❑ 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.