Sterling SPECIALTY PHARMACY

Women's Health
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: _____

What is the patient's diagnosis?

❑ Z30.9 Contraceptive Management

❑ Other: _____

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

For plans subject to the Affordable Care Act, does the attending provider specifically recommend this product as medically necessary and request it be made available to the patient at no cost share as a preventative service? ❑ Yes ❑ No

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

Treatment Used:	Drug Name:	Dates of Treatment:
❑ Injection		
❑ Oral Pill		
❑ Implant Device		
❑ Transdermal Patch		
❑ Intrauterine Device		
❑ Vaginal Ring		
❑ Other: _____		

Would other contraceptives not be effective?

❑ Estrogen concentration swings would cause adverse effects
❑ Higher estrogen doses would cause adverse effects
❑ Lower estrogen doses would increase risk of pregnancy
❑ Unable to adhere to other dosage regimens (e.g., daily)
❑ Vaginal methods not recommended (e.g., frequent infections)
❑ Other: _____

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
❑ TWIRLA®	❑ Twirla (Transdermal Patch) 120-30mcg/24hr	❑ Apply one new patch to clean, dry, hairless area as instructed each week for 3 weeks (21 total days), followed by one week that is patch-free. ❑ Other: _____	❑ 1 Box ❑ 3 Boxes ❑ _____	❑ ___
❑ _____	❑ _____	❑ _____	❑ _____	❑ ___

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.