Sterling SPECIALTY PHARMACY

FLECTOR DIRECT

LICART DIRECT

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.

Prescription Referral Form

NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

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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:

- Strain
- Contusion
- Sprain
- Other: ______

In the prescriber's opinion, Flector/Licart is the best treatment option for the patient because:

- The alternatives would not be as effective for treating the patient's condition.
- The alternatives would likely have adverse effects.
- Patient is stable on current medication and changing to an alternative would likely cause adverse effects.
- The oral alternatives are contraindicated for the patient – explain: ______
- Other: ______

Additional Information: ______

Areas Involved:

Back, Arm, Shoulder, Knee, Neck, Legs, Foot/Calf, Other

Prior Medications Used: Must be completed for all patients.

Treatment Type	Strength	Dates of Use
Ibuprofen		
Diclofenac Oral		
Diclofenac Patch		
Mefenamic Acid		
Indomethacin		
Naproxen		
Diclofenac Topical		
Celecoxib		
Etoricoxib		
Aspirin		
Other: ______		

3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
FLECTOR®	1.3% Patch	**Dose:** Apply one patch topically to clean, dry, hairless area BID. Other: ______	120	___
LICART™	1.3% Patch	**Dose:** Apply one patch topically to clean, dry, hairless area once daily. Other: ______	90	___
______	______	______	___	___

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.