

**Prescription Referral Form**

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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	<b>Dose:</b> Apply one patch topically to clean, dry, hairless area BID. Other: _____	120 ____	____
LICART™	1.3% Patch	<b>Dose:</b> 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.