

# MPP Infusion Centers

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A Multispecialty Physician Partner Company

## STELARA® (USTEKINUMAB) ORDER FORM

REFERRAL STATUS			
<input type="checkbox"/> New Referral <input type="checkbox"/> Order Renewal <input type="checkbox"/> Restart <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> D/C Infusion (Medication(s) to D/C _____)			
LOCATION			
<input type="checkbox"/> Denver <input type="checkbox"/> Arlington <input type="checkbox"/> Dallas <input type="checkbox"/> Duncanville <input type="checkbox"/> Irving <input type="checkbox"/> Lewisville <input type="checkbox"/> Plano <input type="checkbox"/> Southlake <input type="checkbox"/> Tyler			
PATIENT INFORMATION			
PATIENT NAME:		DOB:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS:		PHONE #:	
WEIGHT: _____ LBS    _____ KG	HEIGHT:		EMAIL:
ALLERGIES:			
<b>Please check that the following are included</b>	<input type="checkbox"/> Patient demographics and insurance attached		<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	<input type="checkbox"/> Current Medication List		<input type="checkbox"/> TB Results (w/in 6 months)-if positive, need negative chest Xray and negative TSpot
PHYSICIAN INFORMATION			
Physician Name:		Email (if you would like referral updates):	
Practice Name:		Phone Number:	
Office Contact:		Fax Number:	
DIAGNOSIS			
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Plaque Psoriasis		<input type="checkbox"/> Other:
<input type="checkbox"/> Psoriatic Arthritis			
ICD-10 CODE:		Date of last infusion/injection:	
MEDICATION ORDERS			
<b>STELARA ORDERS:</b> <input type="checkbox"/> Initial Dose: 130 MG IV to equal <input type="checkbox"/> 260 MG <input type="checkbox"/> 390 MG <input type="checkbox"/> 520 MG <input type="checkbox"/> Maintenance Dosing: 2 x 45 MG vials SQ every 8 weeks  <input type="checkbox"/> Dosing: 45 MG vials SQ on week 0, 4, then every 12 weeks <input type="checkbox"/> Dosing: 90 MG vials SQ on week 0, 4, then every 12 weeks (over 100kg)			Notes/Comments
Physician Signature _____ Date (Order is Valid for One Year) _____ Infusion will be administered per MPP policy and protocol			
STANDING LAB ORDERS			
<input type="checkbox"/> Labs to be Drawn by Infusion Center		Frequency: <input type="checkbox"/> Every Infusion <input type="checkbox"/> Other (please specify) _____	
<input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> CRP <input type="checkbox"/> ESRP <input type="checkbox"/> HFR <input type="checkbox"/> UA			
MPP STELARA ORDER FORM_01/2019			