

STELARA® (USTEKINUMAB) ORDER FORM

(* - Required Fields)

___ STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

___ New Referral	___ Order Renewal	___ Medication/Order Change
___ Benefits Verification Only	___ Discontinuation Order	

PATIENT INFORMATION			
NAME*:	DOB*:	SEX:	M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

STELARA ORDER*:		ICD-10*:
(SELECT FROM THE FOLLOWING)		
___ Initial Dosing: Infusion to equal ___ 260 MG ___ 390 MG ___ 520 MG		
___ Dosing: ___ 45MG ___ 90MG vials SQ on week 0, 4, then every 12 weeks		
___ Maintenance Dosing: ___ 45MG ___ 90MG vials SQ every 8 weeks (GI Indication)		
___ Maintenance Dosing: 45MG 90MG vials SQ every 12 weeks		
Physician Signature* _____		Date*(Order is Valid for One Year) _____ <i>Infusion will be administered per MPP policy and protocols</i>

REQUIRED DIAGNOSIS:
___ Crohn's Disease
___ Plaque Psoriasis
___ Psoriatic Arthritis
___ Ulcerative Colitis
___ Other _____
*STAT REASON: (STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:
___ Patient Demographics
___ Insurance Card/Information
___ Clinical/Progress Notes supporting DX
___ Current Medication List and H&P
___ TB Results (w/in 6 months)-if positive, need negative chest Xray and negative TSpot
Last Infusion/Injection Date: _____

STANDING LAB ORDERS: ___ CMP ___ CBC
___ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

- Locations:**
- Colorado-----
- ___ Lakewood
- Florida-----
- ___ Jacksonville
- ___ Kissimmee
- ___ Port St. Lucie
- ___ Winter Park

- Texas-----
- ___ Arlington
- ___ Cedar Hill
- ___ Dallas
- ___ Denton
- ___ Ft. Worth
- ___ Irving
- ___ Rockwall
- ___ Southlake
- ___ Flower Mound
- ___ Plano
- ___ Tyler