MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

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*:

(SELECT FROM THE FOLLOWING)

ICD-10*: _____

☐ 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)** _____

Infusion will be administered per MPP policy and protocols

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
☐ Suncoast
☐ Winter Park

-------- Oklahoma-------
☐ Tulsa

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

REVISION DATE- 10/2021