Stelara SQ (Ustekinumab)

☐ New Referral ☐ Continuing Treatment ☐ Medication Order Change

Patient Information:

Name:_____
Date:_____
DOB:_____
SS#:_____
Phone #:_____
Email:_____

Physician Information:

Referring Physician: _____

Address:_____
_____

Phone #:_____

Fax #:_____

Medication Orders

Patient Weight: _____kg Patient Height: _____inches ☐ First Dose ☐ Maintenance Dose

SQ In-office Dosing: ☐ **45mg SQ** ☐ **90mg SQ**

Frequency: ☐ **Loading Doses: week 0 & 4** ☐ **Maintenance Dose: every 12 weeks** ☐ **Maintenance Dose: every 8 weeks**

Indication / Diagnosis:

- ☐ L40._____ Psoriatic Arthritis
- ☐ L40._____ Psoriasis
- ☐ K50.9_____ Crohn's Disease
- ☐ K51._____ Ulcerative Colitis
- ☐ Other (please specify)_____

ICD-10 (Required) _____

MD Signature: _____**NPI#:**_____ **Date:** _____

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

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