

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



STELARA ORDER FORM

| | | |
|-------------------------------|--------------------|--|
| Patient Name: _____ | ICD-10 Code: _____ | Therapy Status <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____ |
| Date of Birth: _____ | Allergies: _____ | |
| Weight: _____ lbs OR _____ kg | | |

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____
 Provider NPI: _____ Provider Address: _____
 Provider Phone: _____

MEDICATION ORDER

| | | | |
|---|---|---|--|
| <p><i>Please Specify Desired Agent:</i></p> <p>Ustekinumab</p> <p>Therapeutic Interchange to insurance preferred product authorized unless otherwise specified below:</p> <p>_____</p> | <p>Crohn's Disease and Ulcerative Colitis</p> <p><input type="checkbox"/> Initiation- Infuse [] up to 55kg 260mg, [] >55kg-85kg 390mg; [] >85kg 520mg IV over 60 minutes x 1 dose</p> <p><input type="checkbox"/> Maintenance- Inject 90mg SQ 8 weeks after initial dose and every 8 weeks thereafter</p> <hr/> <p>Psoriasis and Psoriatic Arthritis</p> <p><input type="checkbox"/> Initiation- (< or = 100kg) -Inject 45mg SQ on weeks 0 and 4, and every 12 weeks thereafter</p> <p><input type="checkbox"/> Maintenance- (< or = 100kg)- Inject 45mg SQ every 12 weeks</p> <hr/> <p>Psoriasis and Psoriatic Arthritis</p> <p><input type="checkbox"/> Initiation- (greater than 100kg) -Inject 90mg SQ on weeks 0 and 4, and every 12 weeks thereafter</p> <p><input type="checkbox"/> Maintenance- (greater than 100kg)- Inject 90mg SQ every 12 weeks</p> | <p>Refills for one year from date of signature unless indicated below.</p> <p>_____ Refills</p> | <p>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</p> <p><input checked="" type="checkbox"/> Negative TB result and date: _____</p> |
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PRE-MEDICATIONS

| | |
|---|--|
| <p>Oral</p> <p><input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg</p> <p><input type="checkbox"/> Loratadine: 10mg</p> <p><input type="checkbox"/> Cetirizine: 10mg</p> <p><input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</p> <p><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</p> <p><input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg</p> <p><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Other: _____</p> | <p>IV</p> <p><input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</p> <p><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</p> <p><input type="checkbox"/> Methylprednisolone: 125mg</p> <p><input type="checkbox"/> Hydrocortisone: 100mg</p> <p><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Other: _____</p> |
|---|--|

LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

| | |
|---|---|
| <p>**Surveillance lab ordering and monitoring is the responsibility of the prescriber**</p> | <p>(Please fax this signed order form, along with the following documents to 800-223-4063)</p> <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work |
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By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Prescriber Signature _____ Date _____