TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: referral@12stonehealth.com

STELARA ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Please Specify Desired Agent:

Ustekinumab

Therapeutic Interchange to insurance preferred product authorized unless otherwise specified below:

_____

Crohn's Disease and Ulcerative Colitis

☐ Initiation- Infuse [ ] up to 55kg 260mg, [ ] >55kg-85kg 390mg; [ ] >85kg 520mg IV over 60 minutes x 1 dose

☐ Maintenance- Inject 90mg SQ 8 weeks after initial dose and every 8 weeks thereafter

Psoriasis and Psoriatic Arthritis

☐ Initiation- (< or = 100kg) -Inject 45mg SQ on weeks 0 and 4, and every 12 weeks thereafter

☐ Maintenance- (< or = 100kg)- Inject 45mg SQ every 12 weeks

Psoriasis and Psoriatic Arthritis

☐ Initiation- (greater than 100kg) -Inject 90mg SQ on weeks 0 and 4, and every 12 weeks thereafter

☐ Maintenance- (greater than 100kg)- Inject 90mg SQ every 12 weeks

Refills for one year from date of signature unless indicated below.

_____ Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ Negative TB result and date: _____

PRE-MEDICATIONS

Oral

☐ Acetaminophen: _____ 325mg _____ 500mg _____ 650mg

☐ Loratadine: 10mg

☐ Cetirizine: 10mg

☐ Diphenhydramine: _____ 25mg _____ 50mg

☐ Famotidine: _____ 20mg _____ 40mg

☐ Ibuprofen: _____ 200mg _____ 400mg _____ 600mg

☐ Ondansetron: _____ 4mg _____ 8mg

☐ Other: _____

IV

☐ Dexamethasone: _____ 4mg _____ 8mg

☐ Diphenhydramine: _____ 25mg _____ 50mg

☐ Famotidine: _____ 20mg _____ 40mg

☐ Methylprednisolone: 125mg

☐ Hydrocortisone: 100mg

☐ Ondansetron: _____ 4mg _____ 8mg

☐ Other: _____

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

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

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.

Dispense as Written:

_____ _____
Prescriber Signature Date

Substitution Allowed:

_____ _____
Prescriber Signature Date