

**Fairfield**  
1817 Black Rock Turnpike  
Suite 204  
Fairfield, CT 06824

**Greenwich**  
469 W Putnam Ave  
Ste 205,  
Greenwich, CT 06830



# USTEKINUMAB IV Infusion orders

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

USTEKINUMAB BIOSIMILARS:
<input type="checkbox"/> Stelara <input type="checkbox"/> Wezlana <input type="checkbox"/> Selarsdi <input type="checkbox"/> Pyzchiva <input type="checkbox"/> Otulfi <input type="checkbox"/> Yesintek <input type="checkbox"/> Steqeyma

<p><b>DIAGNOSIS</b> <i>Please provide ICD-10 code</i></p> <p><input type="checkbox"/> _____ Crohn's Disease</p> <p><input type="checkbox"/> _____ (other)</p> <p><b>PRE-MEDICATION</b></p> <table> <tr> <td><input type="checkbox"/> Tylenol 1000mg PO</td> <td><input type="checkbox"/> Solu-Medrol 125mg IVP</td> </tr> <tr> <td><input type="checkbox"/> Diphenhydramine 25mg PO</td> <td><input type="checkbox"/> Solu-Cortef 100mg IVP</td> </tr> <tr> <td><input type="checkbox"/> Cetirizine 10mg PO</td> <td><input type="checkbox"/> Diphenhydramine 25mg IVP</td> </tr> </table> <p>_____ (other)                      _____ (other)</p>	<input type="checkbox"/> Tylenol 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP	<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP	<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP	<p><b>PATIENT WEIGHT</b></p> <p>_____ lbs.</p> <p>_____ kg</p> <p><b>DOSAGE:</b></p> <p><input type="checkbox"/> up to 55kg- <b>260mg</b> (2 vials)</p> <p><input type="checkbox"/> greater than 55kg to 85kg - <b>390mg</b> (3 vials)</p> <p><input type="checkbox"/> greater than 85kg - <b>520mg</b> (4 vials)</p> <p><input type="checkbox"/> Other _____</p> <p><b>Frequency:</b></p> <p><input type="checkbox"/> Initial infusion followed by SQ injections self-administered <i>(follow-up maintenance injections to be coordinated by a specialty pharmacy and are not part of this order)</i></p> <p>Route: <input type="checkbox"/> IV <input type="checkbox"/> SQ</p> <p><input type="checkbox"/> Total dosages _____ / <input type="checkbox"/> Refills</p>
<input type="checkbox"/> Tylenol 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP						
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP						
<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP						

<p><b>NOTES/ADDITIONAL COMMENTS:</b></p>     
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*If the medication selected above is not covered or is non-preferred by the patient's insurance, the prescribing provider authorizes consideration of the clinically appropriate alternatives listed below. Final medication selection will be based on provider clinical judgment and/or payer requirements. Provider signature below confirms authorization for the above substitution(s), if applicable.*

USTEKINUMAB BIOSIMILARS :  Stelara     Wezlana     Selarsdi     Pyzchiva     Otulfi     Yesintek     Steqeyma

**ORDERING PROVIDER**

Signature   X   \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_