Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101

Office: 212-803-3339 Fax : 646-768-8600

USTEKINUMAB IV Infusion orders

Date: ____________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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:

☐ **Stelara** ☐ **Wezlana** ☐ **Selarsdi** ☐ **Pyzchiva** ☐ **Otulfi** ☐ **Yesintek** ☐ **Steqeyma**

DIAGNOSIS *Please provide ICD-10 code*

☐ ________ Crohn's Disease

☐ ________ ______________________________________ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
______________________ *(other)*

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
______________________ *(other)*

PATIENT WEIGHT

____________ lbs.

____________ kg

DOSAGE:

☐ up to 55kg- **260mg** (2 vials)
☐ greater than 55kg to 85kg - **390mg** (3 vials)
☐ greater than 85kg - **520mg** (4 vials)

☐ Other______________

Frequency:

☐ Initial infusion followed by SQ injections self-administered
(follow-up maintenance injections to be coordinated by a specialty pharmacy and are not part of this order)

Route: ☐IV ☐SQ

☐ Total dosages________/ ☐Refills

NOTES/ADDITIONAL COMMENTS:

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 ____________