

Hackensack
385 Prospect Avenue
Suite 101
Hackensack, NJ, 07601

Marlton
127 Church Road
Suite 203
Marlton, NJ 08053



Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Somerset
81 Veronica Avenue
Suite 202
Somerset NJ 08873

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:

- Stelara Wezlana Selarsdi Pyzchiva Otulfi Yesintek Steqeyma

<p>DIAGNOSIS <i>Please provide ICD-10 code</i></p> <p><input type="checkbox"/> _____ Crohn's Disease</p> <p><input type="checkbox"/> _____ (other)</p>	<p>PATIENT WEIGHT</p> <p>_____ lbs.</p> <p>_____ kg</p> <p>DOSAGE:</p> <p><input type="checkbox"/> up to 55kg- 260mg (2 vials)</p> <p><input type="checkbox"/> greater than 55kg to 85kg - 390mg (3 vials)</p> <p><input type="checkbox"/> greater than 85kg - 520mg (4 vials)</p> <p><input type="checkbox"/> Other _____</p> <p>Frequency:</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>
<p>PRE-MEDICATION</p> <p><input type="checkbox"/> Tylenol 1000mg PO <input type="checkbox"/> Solu-Medrol 125mg IVP</p> <p><input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Solu-Cortef 100mg IVP</p> <p><input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine 25mg IVP</p> <p>_____ (other) _____ (other)</p>	

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 _____