**Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218

**Forest Hills**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

**NYC**

**E 56th & Park Midtown**
120 East 56 Street
Suite 300
New York, NY 10022

**E 70th St Upper East Side**
225 E 70th Street
Suite 1E
New York, NY 10021

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

Mission Medical

**Tarrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523

**Southampton**
625 Hampton Road
Southampton, NY 11968

**Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030

**Sheepshead Bay**
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

**Long Island City**
36-36 33rd
Suite 311
Long Island City, NY 11106

**FIDI**
30 Broad Street
Suite 401
New York, NY 10004

**Central Park West**
115 Central Park West
Suite 15
New York, NY 10023

**Port Jefferson**
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

**Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901

**Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

**Bronx**
226 West 238th Street
Bronx, NY 10463

**Massapequa**
97 Grand Avenue
Massapequa, NY 11758

**Gramercy**
7 Gramercy Park West
Lower Level
New York, NY, 10003

**Staten Island**
27 New Dorp Lane
Staten Island, NY 10306

**Holbrook**
233 Union Avenue
Suite 207
Holbrook, NY 11741

**New Hyde Park**
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

**Woodbury**
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

# 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 _____