

Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081



Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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>PRE-MEDICATION</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>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>
<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						

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 _____