

Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102



King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

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> <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> <p>_____ (other) _____ (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) <input type="checkbox"/> greater than 55kg to 85kg - 390mg (3 vials) <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>
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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 _____