arise infusion
THERAPY SERVICES

Advanced Treatment for Osteoporosis and Inflammatory Diseases

WHEATON • ROCKVILLE • OLNEY • CHEVY CHASE • FREDERICK • WASHINGTON, DC

STELARA IV/SubQ (*Ustekinumab*) INFUSION REFERRAL CHECKLIST

Patient Name: _____ Date: _____

DOB: _____

Referring Physician: _____ Referring Office Contact: _____

Phone: _____ Fax: _____ Address: _____

Diagnosis: _____ ICD Code: _____

Dose and frequency: _____

Special Instructions: _____

_____

Please send the following documents and records:

- Patient Demographics – Including preferred contact number for patient
- Copy of the patient's insurance card(s) – Front AND Back
- Stelara order signed and dated by referring physician
- Last two most recent office notes (One must include discussion of Stelara) and consultation note
- Most recent labs that include values for:
  - CMP, CBC, HBV Surface Antigen
  - TB screening (PPD, QFT Gold or T Spot)
- Medication History
- If this is a continuation of treatment, include the last infusion note

PLEASE FAX TO 301-424-3590 USING THIS FORM AS THE COVERSHEET

www.ariseinfusion.com
CENTRAL CALL CENTER: 240-514-5000
FAX: 301-424-3590