

STELARA (Ustekinumab) ORDER FORM

REFERRAL TYPE				
<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Restart	<input type="checkbox"/> Frequency Change	<input type="checkbox"/> Dosage Change
PREFERRED LOCATION				
<input type="checkbox"/> 2730 University Blvd. West Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue Suite 600 Chevy Chase, MD 20815		
<input type="checkbox"/> 18111 Prince Philip Drive Suite 323 Olney, MD 20832	<input type="checkbox"/> 71 Thomas Johnson Drive Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW Suite 300 Washington, DC 20006		
		<input type="checkbox"/> 8270 Willow Oaks Corporate Drive Suite 150 Fairfax, VA 22031		
PATIENT INFORMATION				
Name:		DOB:	Email:	
Address:		Weight:	KG	LBS
				Phone:
REFERRING PHYSICIAN INFORMATION				
Name:			NPI:	
Office Contact Name:		Phone:	Fax:	
Address:				
STELARA ORDER				
<i>We do not accept off-label diagnoses, dosages, or frequencies.</i>				
Dosing/Frequency:				
<input type="checkbox"/> Crohn's Initial Dose: <input type="checkbox"/> 260mg IV <input type="checkbox"/> 390g IV <input type="checkbox"/> 520mg IV		<input type="checkbox"/> Crohn's Maintenance Dose: 2 x 45mg injections every 8 weeks		
<input type="checkbox"/> 45mg injection on 0, 4, then every 12 weeks		<input type="checkbox"/> 90mg injection on 0, 4, then every 12 weeks (Weight > 100kg)		
Diagnosis:				
<input type="checkbox"/> K50.00—Crohn's disease of small intestine w/o complications				
<input type="checkbox"/> K50.10—Crohn's disease of large intestine w/o complications				
<input type="checkbox"/> K50.80—Crohn's disease of both small and large intestine w/o complications				
<input type="checkbox"/> L40.0—Psoriasis vulgaris				
<input type="checkbox"/> L40.53—Psoriatic spondylitis				
<input type="checkbox"/> L40.59—Other psoriatic arthropathy				
<input type="checkbox"/> Other Diagnosis:			ICD-10 Code (Required):	
Special Instructions:				
Physicians Signature:			Date: <i>(Order is Valid for One Year)</i>	
REQUIRED DOCUMENTATION				
Please fax the following documents and records:				
<ul style="list-style-type: none"> ● Patient Demographics ● Two most recent office notes (Supporting the DX and treatment ordered) ● Most recent labs that include values for: <ul style="list-style-type: none"> ● CMP, CBC, HBV Surface Antigen ● TB Screening (PPD, QFT Gold or Tspot) 		<ul style="list-style-type: none"> ● Copy of the patient's insurance card(s) – front and back ● Medication History ● For continuation of treatment, include the last infusion note 		
<i>We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.</i>				