MRN:_____

DOB: _____

STANDARD Stelara® (ustekinumab) PLAN OF TREATMENT FOR DERMATOLOGY/RHEUMATOLOGY

NOTE: Patient ***may be ineligible*** to receive ustekinumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. DIAGNOSIS: * **Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing**

☐ **L40.50 Arthropathic psoriasis,** ☐**L40.9 Psoriasis, unspecified**

☐ **L40.52 Psoriatic arthritis** ☐**L40.0 Psoriasis vulgaris** ☐ **L40.53 Psoriatic**

☐ Other **ICD-10 Code:**_____ **Diagnosis description:** _____

4. Dose/Frequency:

Induction dose:

☐ Stelara® (ustekinumab) 45 mg subcutaneous injection at 0 week, 4 week, and then every 12 weeks

☐ Stelara® (ustekinumab) 90 mg subcutaneous injection at 0 week, 4 week, and then every 12 weeks *

Maintenance dose as follows:

☐ Stelara® (ustekinumab) 45 mg subcutaneous injection every 12 weeks

☐ Stelara® (ustekinumab) 90 mg subcutaneous injection every 12 weeks*

*** Note 90 mg dose only suggested for patients greater than 100 kg with Psoriasis or Psoriatic Arthritis with co-existent moderate-to-severe plaque psoriasis.**

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB: _____

Guidelines for Prescribing Stelara® (ustekinumab) for Dermatology/Rheumatology

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- STELARA® (ustekinumab) is indicated for the treatment of adult patients with **moderate to severe plaque psoriasis** who are candidates for phototherapy or systemic therapy. Patients weighing 100 kg or less, the recommended dose is 45 mg initially, 4 weeks later, and then every 12 weeks. For patients weighing more than 100 kg, the recommended dose 90 mg initially, 4 weeks later, and then every 12 weeks.
- Indicated for the treatment of adult patients with **active psoriatic arthritis**, used alone or in combination with methotrexate. The recommended dose is 45 mg initially, 4 weeks later, and then every 12 weeks. For patients with co-existent moderate-to-severe plaque psoriasis weighing more than 100 kg, the recommended dose 90 mg initially, 4 weeks later, and then every 12 weeks.

☐ If patient is switching biological therapies, then MD must specify wash-out period prior to starting Stelara® as specified of_____weeks. Last known biological therapy:_____and last date received:_____.

☐ Other as requested: _____

Pre-Screening: **(TB and Hepatitis screening results must be available prior to start of therapy and within last 12 months.)**

☐ **TB screening test completed.** Results (positive or negative): _____

☐ **Hepatitis B screening test completed.** Results (positive or negative): _____

*If TB or Hep B results are positive, please send documentation of treatment or medical clearance.

** Warnings/Precautions: **Serious Infections:** STELARA® (ustekinumab) may increase the risk of infections and reactivation of latent infections. In patients with psoriasis, serious infections included diverticulitis, cellulitis, pneumonia, appendicitis, cholecystitis, sepsis, osteomyelitis, viral infections, gastroenteritis and urinary tract infections. In patients with psoriatic arthritis, serious infections included cholecystitis. **Reversible Posterior Leukoencephalopathy Syndrome (RPLS):** One case of reversible posterior leukoencephalopathy syndrome (RPLS) was observed in clinical studies of psoriasis and psoriatic arthritis. If RPLS is suspected, administer appropriate treatment and discontinue STELARA®. RPLS is a neurological disorder, which can present with headache, seizures, confusion, and visual disturbances. RPLS has been associated with fatal outcomes. **Concomitant Therapies**: in clinical studies of psoriasis the safety of STELARA® in combination with other immunosuppressive agents or phototherapy was not evaluated. Evaluation of immunizations should be completed prior to and live vaccines should not be given before or concurrently with STELARA ®. Inform patients the needle cover on the prefilled syringe contains dry natural rubber (a derivative of latex), which may cause allergic reactions in individuals sensitive to latex. See full prescribing information.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.