

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Patient preferred clinic:	<input type="checkbox"/> Order Renewal

Stelara® (ustekinumab) Plant of Treatment for Rheumatology & Dermatology

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
	See list
	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

L40.50 - Arthropathic psoriasis, unspecified	L40.0 - Psoriasis vulgaris
L40.59 - Other psoriatic arthropathy	L40.9 - Psoriasis, unspecified
_____ - Other:	

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	REQUIRED: TB screening for new start patients	THERAPY:	
6			
			Continue current order until insurance approved

MEDICATION ORDERS:

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

DOSE/FREQUENCY:

Stelara® (ustekinumab) 45mg subcutaneous injection

Induction: Injection at 0 week, 4 week, and then every 12 weeks

Maintenance: Injection every 12 weeks

Maintenance: Every ____ weeks

Stelara® (ustekinumab) 90mg subcutaneous injection

Induction: Injection at 0 week, 4 week, and then every 12 weeks

Maintenance: Injection every 12 weeks

Maintenance: Every ____ weeks


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

Administer as a subcutaneous injection to the upper arm, gluteal region, thigh, or abdomen

SPECIAL ORDERS:

Refills x 12 months unless noted otherwise here:

NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	
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PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE

Dispense as written/Brand medically necessary	Substitution permitted	



Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com