STELARA (USTEKINUMAB) Referral Order Form   FAX (855) 891-2191

Effective: 05/2017

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528   Referral Fax: (855) 891-2191

Denver   Arlington   Dallas   Duncanville   Irving   Lewisville   Plano   Southlake

New Referral   Benefits Verification Only   D/C Infusions *indicate name of drug(s) ________________

PATIENT INFORMATION

Name: ________________________ Date: _________

DOB: ________________ SS# _________________

Phone # ___________________

Email: ____

PHYSICIAN INFORMATION

Referring Physician: _________________________________

Practice Name: _________________________________

Specialty: _________________________________

Office Contact: _________________________________

Contact Phone # __________ Contact Fax # __________

Contact Email: _________________________________

STELARA MEDICATION ORDERS

Patient Weight: _____kg

INDICATION/DIAGNOSIS

Crohn's Disease Initial   ***ICD-10** __________________________ **required**

Initial Dosing: __________   130 MG vials to equal   260 MG   390 MG   520 MG

Maintenance Dosing: 2 x 45 MG vials SQ every 8 weeks

PSA   Psoriasis   ***ICD-10** __________________________ **required**

Dosing: _________ 45 MG vials SQ on week 0, 4, then every 12 weeks

NOTES (ADDITIONAL INFO)

*valid for one year

______________________________ Referring Physician's Signature   ________ Date

REQUIRED DOCUMENTATION

Recent Office notes (along with any therapies tried and outcomes)   Current Medication List   History and Physical Report (w/in past 6 months)

Lab Results   Insurance Cards (front and back)   Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

TB Results (w/in 6 months)

APPOINTMENT DATE & TIME: ______________________________

FOR OFFICE USE ONLY