Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
☐ Active Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ TB Test Results

*Patient may be required to submit a pregnancy test prior to treatment

- ☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 year)
- ☐ Labs and Tests supporting primary diagnosis
- ☐ Hepatitis B Test Results: HBsAg & HepB Core w/reflex IgG and IgM

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Plaque Psoriasis Dosing	☐ Stelara 45mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight ≤ 100kg) ☐ Stelara 90mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight > 100kg)
Psoriatic Arthritis Dosing	☐ Stelara 45mg SubQ at Week 0, 4, then every 12 weeks thereafter ☐ Other: Stelara _____ mg SubQ _____
Crohn's Disease and Ulcerative Colitis Dosing	Initial IV dose (choose one): ☐ Stelara 260mg IV x1 for Weight <55kg ☐ Stelara 390mg IV x1 for Weight 55-85kg ☐ Stelara 520mg IV x1 for Weight >85kg Maintenance Dosing (will start 8 weeks after IV dose, when applicable): ☐ Stelara 90mg SubQ every 8 weeks

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - STELARA (USTEKINUMAB)

Clinics Scan to: Physician Orders