# Stelara® Referral Form

Phone: (877)-246-9104
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www.biotekrx.com

| PATIENT INFORMATION (Complete or fax existing chart) | | | | PRESCRIBER INFORMATION | |
|---|---|---|---|---|---|
| Patient Name: | | | | Prescriber Name: | |
| Address: | | | | State License: | NPI#: |
| City, State, Zip: | | | | DEA: | Phone: |
| Phone: | | 2nd Phone: | | Address: | Fax: |
| DOB: | Gender: ☐ Male ☐ Female | | | City, State, Zip: | |
| Weight: | Ht: | Allergies: | | Contact Person: | Phone: |

| INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s) | | | |
|---|---|---|---|
| Primary Insurance: | | RX Card (PBM): | |
| City, State, Zip: | | BIN: | PCN: |
| Plan# | Group# | City, State, Zip: | |
| Phone: | | Plan# | Group# |

## DIAGNOSIS

- ☐ **Adult with moderate to severe Plaque Psoriasis** - ICD Code(s): ___________________________________________________
- ☐ **Adult with active Psoriatic Arthritis -** ICD Code(s): ___________________________________________________
- ☐ **Adult with moderately to severely active Crohn's Disease** – ICD Code(s): ___________________________________________________
- ☐ **Adult with moderately to severely active Ulcerative Colitis** – ICD Code(s): ___________________________________________________
- ☐ **Age 6 years – 18 years with moderate to severe Plaque Psoriasis** – ICD Codes (s):_____________________________________________
- ☐ **Age 6 years -18 years with active Psoriatic Arthritis** – ICD Code(s): ___________________________________________________
- ☐ **Other** – ICD Code(s):__________________

## ONE-TIME IV INDUCTION DOSING: (For use with Adult Crohn's Disease and Ulcerative Colitis only)

Patient previously received induction dose: Yes____ No______ Date of infusion: __________ Induction dose:_____________

Patient weight:_____________

- ☐ 55 kg or less: 260 mg (2 x 130 mg/26 mL vials) at Week 0:
- ☐ more than 55 kg to 85 kg: 390 mg (3 x 130 mg/26 mL vials) at Week 0:
- ☐ more than 85 kg: 520 mg (4 x 130 mg/26 mL vials) at Week 0:

## REQUIRED PRE- TREATMENT EVALUATION:

**Tuberculosis Screening**:

- ☐ **Complete** – Negative Results Attached and patient may proceed with therapy
- ☐ **Complete** – Positive Results Attached – TB treatment initiated – Must complete adequate course of therapy prior to proceeding with therapy
- ☐ **In Process** – Results Pending

## OPTIONAL PREMEDICATIONS

| | |
|---|---|
| ☐ Acetaminophen 500 mg | ☐ Acetaminophen 1000 mg |
| ☐ Diphenhydramine 25 mg PO | ☐ Zyrtec 10 mg PO |
| ☐ Diphenhydramine 25 mg IV | ☐ Famotidine 20mg IV |
| ☐ Solu-Medrol 125 mg SIVP | |

## SUBCUTANEOUS PRESCRIPTION INFORMATION

| **Patient Weight _______ kg** | **Dosing:** | **Interval:** |
|---|---|---|
| | ☐ 90mg single-dose prefilled syringe for subcutaneous injection | ☐ Initial does ☐ 4 weeks later ☐ 8 weeks later<br>☐ every 8 weeks ☐ every 12 weeks |
| | ☐ 45mg single-dose prefilled syringe for subcutaneous injection | ☐ Initial does ☐ 4 weeks later ☐ 8 weeks later<br>☐ every 8 weeks ☐ every 12 weeks |
| | ☐ 45mg single-dose vial for subcutaneous injection | ☐ Initial does ☐ 4 weeks later ☐ 8 weeks later<br>☐ every 8 weeks ☐ every 12 weeks |
| | ☐ 0.75mg/kg = ______________mg | ☐ Initial does ☐ 4 weeks later ☐ 8 weeks later<br>☐ every 8 weeks ☐ every 12 weeks |

## SIGNATURE

x Date:

(Product Substitution Permitted)

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