FAX: 800-987-6552
Phone: 877-283-8679

Stelara (ustekinumab) Rheumatology Patient Referral

PATIENT INFORMATION

Patient Name:	Ship to: ☐ Home ☐ Office		DOB:	
Home Address:	City:		State:	Zip:
Home Phone:	Height:	Weight:	Gender: ☐ Male ☐ Female	
Cell Phone:	Email Address:			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy#:	Group#:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION (fax all pertinent clinical and lab information)

Diagnosis (ICD-10):	Date of Diagnosis:	List of Failed Therapies:	
Is patient switching from other biologic therapy? ☐ Yes ☐ No	Date of last infusion:	Required washout period: _____ wks	
Negative TB Test: ☐ Yes ☐ No	Previously vaccinated against Hepatitis B or Negative HBsAg? ☐ Yes ☐ No		
List additional comorbidities:	Allergies:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Stelara Induction Doses (select one)	☐ 45 mg (0.5 mL) subcutaneously at week 0 and 4, OR
	☐ *90 mg (1mL) subcutaneously at week 0 and 4
Stelara Maintenance Dose (select one)	☐ 45 mg (0.5 mL) subcutaneously once every 12 weeks, OR
	☐ *90 mg (1mL) subcutaneously once every 12 weeks
	***90mg Stelara dose is only recommended for patients > 100 KG with Psoriasis/Psoriatic Arthritis with co-existing moderate to severe plaque psoriasis.**

Refill for Subcutaneous Maintenance Dose: **PRN x 1 year (OR _____ times)**

Anaphylaxis Orders and Medications	☐ Provide epinephrine auto-injector 2-pack per pharmacy protocol.
Ancillary Supplies	☐ Provide supplies as needed for administration, and appropriate disposal of infusion materials.
Skilled Nursing Orders	☐ Provide skilled nursing for training of self-injection.
	☐ No nursing administration or education needed.

Administration procedures to be followed per pharmacy protocol or manufacturer's guidelines.

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email Address:	
Address:		
NPI:		

Prescriber Signature: Date:

Your signature authorizes AvevoRx, LLC and their network of pharmacies, Mid-Valley Health System (the "AvevoRx Pharmacies"), to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

***Referral forms are not considered legal prescriptions for certain payers and in certain states, including AL. AvevoRx, or it's partner pharmacies may request additional prescription orders where required by local state Board of Pharmacy regulations or specific payer restrictions.