AYSA
THERAPEUTICS INFUSION

STELARA (USTEKINUMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ____________________ DOB: ____________ Phone: ____________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: __________ lbs.

Allergies: ______________________________

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ TB documentation attached

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(optional)*

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ______________________________

STELARA ORDERS

Diagnosis: ☐ Plaque Psoriasis ICD-10 Code: __________ ☐ Psoriatic Arthritis ICD-10 Code: __________

☐ Patients weighing < 100kg (220 lbs.), 45mg subQ initially and 4 weeks later, followed by 45mg every 12 weeks

☐ Patients weighing > 100kg (220 lbs.), 90mg subQ initially and 4 weeks later, followed by 90mg every 12 weeks

☐ Other: ______________________________

Diagnosis: ☐ Crohn's Disease ICD-10 Code: __________ ☐ Ulcerative Colitis ICD-10 Code: __________

Stelara Initial Infusion:
☐ <55kg (121 lbs.) 260mg IV over 1 hour x 1 dose
☐ 55kg to 85kg (121 lbs. to 187 lbs.) 390mg IV over 1 hour x 1 dose
☐ >85kg (187lbs.) 520mg IV over 1 hour x 1 dose

Stelara Maintenance: ☐ 90mg SQ 8 weeks after initial infusion and then refill every 8 weeks for 1 year for a total of 6 refills

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ____________________ Physician Name: ____________________ Date: __________
Phone: ____________________ Fax: ____________________ Contact Person: ____________________

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