

# TwelveStone Health Partners

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## STELARA ORDER FORM

Date: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs OR \_\_\_\_\_ kg

**Therapy Status**  
 New Start  
 Continuing Therapy: Last Dose: \_\_\_\_\_

### PROVIDER INFORMATION

Ordering Provider: \_\_\_\_\_ Provider Fax: \_\_\_\_\_  
 Provider NPI: \_\_\_\_\_ Provider Address: \_\_\_\_\_  
 Provider Phone: \_\_\_\_\_

### MEDICATION ORDER

|                |  |  |  |
|----------------|--|--|--|
| <b>Stelara</b> | <b>Crohn's Disease and Ulcerative Colitis</b><br><input type="checkbox"/> Initiation- Infuse [ ] up to 55kg 260mg, [ ] >55kg-85kg 390mg; [ ] >85kg 520mg IV over 60 minutes x 1 dose<br><input type="checkbox"/> Maintenance- Inject 90mg SQ 8 weeks after initial dose and every 8 weeks thereafter | Refills for one year from date of signature unless indicated below.<br><br>_____ Refills | <p><b>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</b></p> <p>✓ Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months.</p> |
|                | <b>Psoriasis and Psoriatic Arthritis</b><br><input type="checkbox"/> Initiation- (< or = 100kg) -Inject 45mg SQ on weeks 0 and 4, and every 12 weeks thereafter<br><input type="checkbox"/> Maintenance- (< or = 100kg)- Inject 45mg SQ every 12 weeks   |  |  |
|                | <b>Psoriasis and Psoriatic Arthritis</b><br><input type="checkbox"/> Initiation- (greater than 100kg) -Inject 90mg SQ on weeks 0 and 4, and every 12 weeks thereafter<br><input type="checkbox"/> Maintenance- (greater than 100kg)- Inject 90mg SQ every 12 weeks                                   |  |  |

### PRE-MEDICATIONS

**Oral**

Acetaminophen: \_\_\_\_\_ 325mg \_\_\_\_\_ 500mg \_\_\_\_\_ 650mg

Loratadine: 10mg

Cetirizine: 10mg

Diphenhydramine: \_\_\_\_\_ 25mg \_\_\_\_\_ 50mg

Famotidine: \_\_\_\_\_ 20mg \_\_\_\_\_ 40mg

Ibuprofen: \_\_\_\_\_ 200mg \_\_\_\_\_ 400mg \_\_\_\_\_ 600mg

Ondansetron: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg

Other: \_\_\_\_\_

**IV**

Dexamethasone: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg

Diphenhydramine: \_\_\_\_\_ 25mg \_\_\_\_\_ 50mg

Famotidine: \_\_\_\_\_ 20mg \_\_\_\_\_ 40mg

Methylprednisolone: 125mg

Hydrocortisone: 100mg

Ondansetron: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg

Other: \_\_\_\_\_

### LAB ORDERS (please indicate any labs to be drawn and frequency)

### OTHER REQUIRED DOCUMENTATION

\*\*Surveillance lab ordering and monitoring is the responsibility of the prescriber\*\*

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written: \_\_\_\_\_

Prescriber Name \_\_\_\_\_ Date \_\_\_\_\_

Substitution Allowed: \_\_\_\_\_

Prescriber Name \_\_\_\_\_ Date \_\_\_\_\_