Stelara Order Form

Pre-filled order form for Stelara (ustekinumab) — IL-12/23 inhibitor for IBD and psoriasis

REFERRING PROVIDER

PROVIDER NAME	NPI	DEA (IF CONTROLLED)	SPECIALTY

PRACTICE / CLINIC NAME	OFFICE PHONE	OFFICE FAX

OFFICE CONTACT NAME	CONTACT PHONE	CONTACT EMAIL

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	SEX	PATIENT PHONE	BEST TIME TO CONTACT

ADDRESS	CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE	MEMBER ID	GROUP #

SECONDARY INSURANCE (IF ANY)	MEMBER ID	GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS	ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE)	ICD-10 CODE

Common indications for this medication: *Crohn’s disease, Ulcerative colitis, Plaque psoriasis (moderate to severe), Psoriatic arthritis*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

STELARA REFERENCE

Generic name: ustekinumab

Specialty: Gastroenterology & Dermatology

Typical infusion time: About 1 hour

Typical schedule: IV induction once, then maintenance every 8 weeks

Biosimilars / brands: Selarsdi, Wezlana, Pyzchiva

MEDICATION ORDER

MEDICATION (DEFAULT: STELARA)	GENERIC / ALT (USTEKINUMAB)	STRENGTH / FORMULATION

DOSE	FREQUENCY (TYPICAL: IV INDUCTION ONCE, THEN MAINTENANCE EVERY 8 WEEKS)	DURATION (TYPICAL: ABOUT 1 HOUR)

ROUTE	PRE-MEDICATIONS (IF ANY)	SPECIAL INSTRUCTIONS

ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)	BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Arbor to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ Other (specify below)

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE	PRINTED NAME	DATE

Form code: ARB-ORDER-STELARA · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com