STELARA® (ustekinumab)
Order/Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

10750 W. Howard Avenue
Greenfield, WI 53228
Phone: (414) 460-3195
Fax: (414) 763-0063
www.gtinfusions.com

Patient Information	
Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart/Continuation ☐ Medication/Order Change ☐ D/C Infusions

Diagnosis and ICD 10 Code	
☐ Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
☐ Active Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Other Diagnosis:	ICD 10 Code:

Supporting Documentation	
☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests including baseline liver function test
☐ TB Test Results	☐ Hepatitis B Results: HBsAg & HepB Core w/reflex IgG and IgM
☐ Tried and Failed therapies	☐ Current Medication List

Medication Orders	
Plaque Psoriasis Dose:	☐ STELARA® 45mg SubQ at week 0, 4, then every 12 weeks thereafter (Patient Weight ≤ 100kg) ☐ STELARA® 90mg SubQ at week 0, 4, then every 12 weeks thereafter (Patient Weight > 100kg)
Psoriatic Arthritis Dose:	☐ STELARA® 45mg SubQ at week 0, 4, then every 12 weeks thereafter
Crohn's Disease and Ulcerative Colitis Dosing:	☐ Initial Dose: STELARA® 260mg IV x 1 for weigh <55kg ☐ Initial Dose: STELARA® 390mg IV x 1 for weigh 55kg - 85kg ☐ Initial Dose: STELARA® 520mg IV x 1 for weigh >85kg ☐ Maintenance Dose: STELARA® 90mg SubQ every 8 weeks

Premedication

☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg or 50 mg PO or IV
☐ Cetirizine 10mg PO or IV
☐ Methylprednisolone IV _____mg

Notes (Additional Info)

Adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.

Prescriber Information		
Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order valid for one year)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.