PREMIER VITALITY

Physician-led · Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

STELARA ORDER DERMATOLOGY

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:		Fax:
Patient Name:		DOB:

Allergies ☐ NKDA ☐ Allergies:

_____ Height:

_____ Weight: _____

Indication:

☐ L40.52 Active psoriatic arthritis
☐ L40.0 Moderate to severe plaque psoriasis
☐ Other _____

DRUG:

☐ **PsO:**
  ☐ ≤100kg- 45mg SQ at weeks 0, 4, then every 12 weeks
  ☐ ≥100kg- 90mg SQ at weeks 0, 4 then every 12 weeks
☐ **PsA:** 45mg SQ at weeks 0, 4, then every 12 weeks
☐ **PsA with Mod-Severe PsO:**
  ☐ ≤100kg- 45mg SQ at weeks 0, 4, then every 12 weeks
  ☐ ≥100kg- 90mg SQ at weeks 0, 4 then every 12 weeks
☐ Other_____

Prescriber Name:	Title:

NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive <u>ALL</u> the following:

☐ Face Sheet / Patient Demographics

☐ Insurance card(s) – copy of front & back

☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐ TB ☐ Hep B Other: _____