



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

STELARA ORDER DERMATOLOGY

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> 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 ALL 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: _____