Ascend
INFUSION CENTERS

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 ☐ 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 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: ____