New Prescription/Referral Prescription Refill

Of Refills:

RX:	<u>Iame:</u>		Patient Weigh	nt: DOB:		
Stelara:	Diagnosis: Plaque Psoriasis Psoriatic Arthritis ICD-10 Code: Weight ≤ 100kg: Stelara 45mg subQ at weeks 0, 4, and every 12 weeks thereafter x 1 year Weight > 100kg: Stelara 90mg subQ at weeks 0, 4, and every 12 weeks thereafter x 1 year Others:					
(ustekinumab)	Initial Doses: Wei Wei Wei Maintenance Doses:	ght < 56kg: 260mg l ght 56kg - 85kg: 390 ght > 85kg: 520mg l 90mg SubQ ever	Omg IV infusion at week 0 IV infusion at week 0)	:	
Pre-Medicatio	on:				ANA Kit Protocol:	
Solumedrol 125m Solu-Cortef 100m Others:	•		Benadryl 25 mg 50 mg	C	OK to use	
Dx: Diagnosi						
Physician Signature			NPI #:	DATE:(\	DATE:(Valid for 1 year)	
By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.						
PHYSICIAN INFO	RMATION		Clinic:			
Physician Name: Phone:	Fax: Email:		Cimic.	Other:		
Office Mailing Addre	88:					
Please include the following Patient demographics Insurance attached Diagnosis(supporting) History & Physical Clinical progress notes Medication list Other Test Results TB screening test within 12 months - attach results *If TB results are positive - please provide documentation of treatment or medical clearance, and a negative CXF						