USTEKINUMAB ORDER SET

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Route		Refills
□Ustekinumab **OR** ustekinumab biosimilar *Preferred product TBD after benefits investigation (noted below) □ Do not substitute Give the following ustekinumab product: _____	**IV**	□ 260mg IV (<56kg) □ 390mg IV (56-85kg) □ 520mg IV (>85kg)	None
	SubQ	SubQ doses to be evaluated by LIVbetter Specialty Pharmacy □ 45mg subQ initially and 4 weeks later, followed by 45mg every 12 weeks □ 90mg subQ initially and 4 weeks later, followed by 90mg every 12 weeks □ 90mg subQ 8 weeks after initial infusion and then every 8 weeks □ 45mg subQ every 12 weeks □ 90mg subQ every 8 weeks □ 90mg subQ every 12 weeks □ Other: _____	□ x 1 year □ _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

Required labs to be drawn by □ LIVbetter Infusions □ Referring Provider

*FOR LIVbetter USE ONLY

Drug/Brand Selection: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR USTEKINUMAB THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

□Include signed and completed order (MD/prescriber to complete page 1)

□Include patient demographic information and insurance information

□Include patient's medication list

□Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- □Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, 6-MP)? □ Yes □ No
  If yes, which drug(s)? _____
- □Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Otezla, Stelara, Cimzia)? □ Yes □ No
  If yes, which drug(s)? _____
- □If psoriasis diagnosis, percent of body surface (BSA) involved: _____ %
- □If psoriasis diagnosis, Psoriasis Area and Severity Index (PASI) score: _____

□Include labs and/or test results to support diagnosis

□*If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting ustekinumab.

□Other medical necessity: _____

REQUIRED PRE-SCREENING

□TB screening test (completed within 12 months if a new start) - attach results

□Positive □ Negative

*If TB results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)