March 2024

LOWCOUNTRY
**Rheumatology**
A Member of Articularis Healthcare Group,Inc.

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 <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: _____