

# Ustekinumab IV Biosimilars

Provider Order Form Rev. 03/2026

Please fax completed referral form & all required documents to (833) 786-0025



## PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Allergies: \_\_\_\_\_  NKDA Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  in  cm  
**Patient Status:**  New to Therapy  Dose or Frequency Change  Order Renewal

**INSURANCE INFORMATION: Please attach copy of insurance card (front and back).**

## DIAGNOSIS\*

**\*ICD 10 Code  
Required**

Crohn's Disease (K50.00-K50.919), ICD10 \_\_\_\_\_  
 Ulcerative Colitis (K51.00-K51.919), ICD10 \_\_\_\_\_  
 Other: \_\_\_\_\_, ICD10 \_\_\_\_\_

## INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Ustekinumab biosimilars available: <input type="checkbox"/> Stelara® (ustekinumab) <input type="checkbox"/> Wezlana® (ustekinumab-auub) <input type="checkbox"/> Selarsdi® (ustekinumab-aekn) <input type="checkbox"/> Pyzchiva® (ustekinumab-ttwe) <input type="checkbox"/> Otulfi® (ustekinumab-aaaz) <input type="checkbox"/> Imuldosa® (ustekinumab-srlf) <input type="checkbox"/> Yesintek® (ustekinumab-kfce) <input type="checkbox"/> Steqeyma® (ustekinumab-stba) <input type="checkbox"/> Starjemza® (ustekinumab-hmny)	<b>INITIAL IV Dose</b> <input type="checkbox"/> <55kg: 260 mg <input type="checkbox"/> 55kg to 85kg: 390 mg <input type="checkbox"/> >85kg: 520 mg	Infuse IV over 1 hour x 1 dose.

**Is patient currently receiving therapy above from another facility?**

Yes  No

If yes, Facility Name: \_\_\_\_\_

Date of last treatment: \_\_\_\_\_ Date of next treatment: \_\_\_\_\_

## PRE-MEDICATION ORDERS

No premeds ordered at this time  
 Acetaminophen 650mg PO  Diphenhydramine 25mg PO  
 Methylprednisolone 40mg IVP -OR-  Hydrocortisone 100mg IVP  
 Other: \_\_\_\_\_

## LAB ORDERS

**Labs to be drawn by:**  Infusion Center  Referring Physician  
 No labs ordered at this time  
 CBC q \_\_\_\_\_  CMP q \_\_\_\_\_  CRP q \_\_\_\_\_  
 ESR q \_\_\_\_\_  LFTs q \_\_\_\_\_  Other: \_\_\_\_\_

## REFERRING PHYSICIAN INFORMATION

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_ TIN: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Email Where Follow Up Documentation Should Be Sent: \_\_\_\_\_

## REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

## LAB AND TEST RESULTS (required)

- Provide copy of TB screening (within 12 months) and must be completed annually by:  Infusion Center  Referring Physician
- Provide copy of Hepatitis B Screening
- Provide copy of baseline CBC, CMP and LFT

## PRIOR FAILED THERAPIES (including corticosteroids, antimalarials, NSAIDs, immunosuppressants)

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
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