Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Stelara Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 996-0145
F.(856) 770-8271 ~ Attn: Stephanie D

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	▫ Voorhees ▫ Moorestown ▫ Wall/Manasquan ▫ Sewell ▫ Hamilton ▫ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Diagnosis:

☐ K50.90 Crohn's disease ☐ K51.90 Ulcerative colitis

☐ Other: _____

The following information is required for all patients for authorization for Stelara:

- Copy of a NEGATIVE TB test (Quantiferon, T-Spot, PPD)

- Is the patient currently treated with another biologic?
  ☐ YES ☐ NO

- Is the prescriber a gastroenterologist, or has prescribed the medication in consultation with a gastroenterologist?
  ☐ YES ☐ NO

- Has the patient had an inadequate response to a conventional agent (such as azathioprine, corticosteroids, sulfasalazine, etc.) after treatment for at least 3 months?
  ☐ YES ☐ NO

- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents (circle)?
  - 6- mercaptopurine,
  - azathioprine,
  - corticosteroids,
  - balsalazide,
  - methotrexate,
  - sulfasalazine,
  - cyclosporine,
  - mesalamine,
  - or steroid suppositories.

- Has the patient tried another biologic immunomodulator agent that is FDA labeled for this condition? ☐ YES ☐ NO

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.

    - ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
    - *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
    - *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*

- Please provide any clinical information to support the start of Stelara.
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** Please notify our office if medication is discontinued.

Ordering Provider Signature:

_____