

Stelara Request Form

2301 Evesham Road, Building 800, Suite 115

Voorhees, New Jersey 08043

T. (866)497-09055

F.(609)228-9798 Attn: Idyllic Infusion Coordinator

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	
<p><i>We will gladly remind your patient to schedule routine follow-up visits with your office.</i></p> <p>Return to Referring Provider (frequency): EVERY _____ WKS / MOS</p>	
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	<input type="checkbox"/> Voorhees <input type="checkbox"/> Moorestown <input type="checkbox"/> Wall/Manasquan <input type="checkbox"/> Sewell <input type="checkbox"/> Hamilton <input type="checkbox"/> 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:
