**Please fax both pages of completed form to your team at 808.650.6487.**
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form
# Stelara® (ustekinumab) – Intravenous

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

**Four simple steps to submit your referral.**

## 1 Patient Information

**Please provide copies of front and back of all medical and prescription insurance cards.**

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

☐ Male ☐ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

## 2 Prescriber Information

**All fields must be completed to expedite prescription fulfillment.**

Date _____ Time _____ Date medication needed _____

**Prescriber info:** Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below:

**Infusion info:** Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion clinic contact name _____ Phone _____ E-mail _____

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** _____ Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No Please list all therapies tried/failed: _____

Patient wt _____ Date wt obtained _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient's rst name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's rst name _____ Last name _____ Phone _____

## 4 Prescribing Information

| Medication | Dose | Directions | Quantity/Refill |
|---|---|---|---|
| Stelara® (ustekinumab) | ☐ ≤ 55kg 260mg intravenously (IV) as a single dose.<br>☐ > 55kg to 85kg 390mg IV as a single dose.<br>☐ > 85kg 520mg IV as a single dose. | Infuse over a minimum of 1 hour. | ☐ 8-week supply for induction.<br>☐ Other<br>_____<br>No re lls |

If shipped to physician's of ce, physician accepts on behalf of patient for administration in of ce.

**Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)**

**SIGN HERE**

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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