CarePartners Specialty Infusion

Phone : 866-852-6264 Fax : 866-832-7180

IMULDOSA® (USTEKINUMAB-SRLF) RX ENROLLMENT FORM

PATIENT INFORMATION

Patient Name:		Date of Birth:	Gender:
Home Phone:	Cell Phone:	Email:	
Address:	City:	State:	Zip:
Emergency Contact:		Emergency Phone:	

CLINICAL INFORMATION

Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

Allergies: _____

Primary Diagnosis: ☐ Crohn's Disease (K50) ☐ Plaque Psoriasis (L40)
☐ Ulcerative Colitis (K51) ☐ Psoriatic Arthritis (L40.52)

For Patients with Psoriasis, % BSA Affected: _____

TB/PPD Test: ☐ Positive ☐ Negative Date Read: _____

List of Failed Treatments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

DEA #: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____

PRESCRIPTION INFORMATION **Please select a Loading Dose only if required.**

Site of Infusion: ☐ MD has provided training & authorizes patient or caregiver to administer SC injections
☐ Prescriber's Office/Hospital Outpatient/Infusion Center/Other: _____

Plaque Psoriasis Adult/Pediatric patients age ≥ 6 and weight ≥ 60kg — **Date of Last Dose (if known):**

Subcutaneous Loading Dose:

☐ ≤100kg: **IMULDOSA® (ustekinumab-srlf) 45mg/0.5mL PFS**
Administer 1 injection (45mg) SC at Week 0. Then start Maintenance Prescription at Week 4. Quantity: 1 injection, Refills: 0

☐ >100kg: **IMULDOSA® (ustekinumab-srlf) 90mg/mL PFS**
Administer 1 injection (90mg) SC at Week 0. Then start Maintenance Prescription at Week 4. Quantity: 1 injection, Refills: 0

☐ Other: _____

Subcutaneous Maintenance Dose: **Refills**

☐ ≤100kg: **IMULDOSA® (ustekinumab-srlf) 45mg/0.5mL PFS**
Administer 1 injection (45mg) SC every 12 weeks. Quantity: 1 injection ☐

☐ >100kg: **IMULDOSA® (ustekinumab-srlf) 90mg/mL PFS**
Administer 1 injection (90mg) SC every 12 weeks. Quantity: 1 injection ☐

☐ Other: _____ ☐

Psoriatic Arthritis Adult/Pediatric patients age ≥ 6 and weight ≥ 60kg — **Date of Last Dose (if known):**

Subcutaneous Loading Dose:

☐ **IMULDOSA® (ustekinumab-srlf) 45mg/0.5mL PFS**
Administer 1 injection (45mg) SC at Week 0. Then start Maintenance Prescription at Week 4. Quantity: 1 injection, Refills: 0

☐ >100kg w/ mod-severe Plaque Psoriasis:
IMULDOSA® (ustekinumab-srlf) 90mg/mL PFS
Administer 1 injection (90mg) SC at Week 0. Then start Maintenance Prescription at Week 4. Quantity: 1 injection, Refills: 0

☐ Other: _____

Subcutaneous Maintenance Dose: **Refills**

☐ **IMULDOSA® (ustekinumab-srlf) 45mg/0.5mL PFS**
Administer 1 injection (45mg) SC every 12 weeks. Quantity: 1 injection ☐

☐ >100kg w/ mod-severe Plaque Psoriasis:
IMULDOSA® (ustekinumab-srlf) 90mg/mL PFS
Administer 1 injection (90mg) SC every 12 weeks. Quantity: 1 injection ☐

☐ Other: _____ ☐

Crohn's Disease/ Ulcerative Colitis (Adult) — **Date of Last Dose (if known):**

IV Loading Dose (given as a single intravenous infusion)

☐ ≤55kg: **260mg** IV at week 0. Then start subcutaneous Maintenance Prescription at Week 8. Dispense 2 vials.

☐ >55kg-85kg: **390mg** IV at week 0. Then start subcutaneous Maintenance Prescription at Week 8.Dispense 3 vials.

☐ >85kg: **520mg** IV at week 0. Then start subcutaneous Maintenance Prescription at Week 8. Dispense 4 vials.

☐ Other: _____

Infuse intravenously once over at least 1 hour, Refills: 0
IMULDOSA® (ustekinumab-srlf) 130mg/26mL solution in single-dose vials will be dispensed to fulfill dose.

Subcutaneous Maintenance Dose: **Refills**

☐ **IMULDOSA® (ustekinumab-srlf) 90mg/mL PFS**
Administer 1 injection (90mg) SC every 8 weeks. Quantity: 1 injection ☐

☐ Other: _____ ☐

Shipping information for IV Loading Dose to be administered by a healthcare provider (Note: Shipments cannot be sent to PO boxes)

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

☐ May Substitute/Product Selection Permitted/Substitution Permissible
Prescriber Signature _____ **Date** _____

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
Prescriber Signature _____ **Date** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" **NY & Iowa** providers, please submit electronic prescription.

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