

North Texas Infusion Specialty Pharmacy and Infusion Centers
 3409 Worth St. #710 Dallas, TX 75246 (214) 823-2533 FAX (214) 887-0436 www.NTISP.org
Stelara Enrollment Form

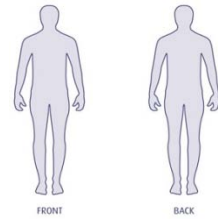
Patient Information: Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Alt. Phone: _____ SS#: _____ DOB: _____ Gender: _____	Physician Information: Physician Name: _____ Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____ Contact Person: _____ DEA#: _____
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Primary Insurance Information Insurance Name _____ Cardholder Name _____ Group/Policy # _____	Secondary Insurance Information Insurance Name _____ Cardholder Name _____ Group/Policy# _____	Pharmacy Insurance Information Insurance Name _____ Member ID _____ BIN Number _____ Group # _____
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Statement of Medical Necessity

Diagnosis:
 696.1 Psoriasis 696.0 Psoriatic Arthritis Other _____ * _____ BSA% affected by Psoriasis
 Date of DX: _____

Patient Evaluation:
 *Has patient been diagnosed with heart failure? yes no
 *Has patient been diagnosed with Lymphoma? yes no
 *Does patient have serious/active infection? yes no
 *Has TB test been performed? yes no
 If yes, results: _____ Comments: _____
 *Has Hepatitis B been ruled out or treatment been initiated? yes no
 *Does patient have a latex allergy? yes no
 *Is patient's platelet count >52,000 cells/uL? yes no
 *Patients weight: _____ *Patients height: _____
 *Allergies: _____ NKDA



Medical Assessment (Within Last 12 months)
 Psoriasis Severity Moderate Moderate to Severe Severe
 Psoriasis Type Plaque Other(specify) _____

Prior (Failed) Medications:	Medication	Reason for Discontinuation
<input type="checkbox"/> Biologics	_____	_____
<input type="checkbox"/> Methotrexate	N/A	_____
<input type="checkbox"/> Oral Meds	_____	_____
<input type="checkbox"/> PUVA	N/A	_____
<input type="checkbox"/> UVB	N/A	_____
<input type="checkbox"/> Topicals	_____	_____
<input type="checkbox"/> Other	_____	_____

Prescription Information: (Please choose induction & maintenance dose)

Medication	Strength	Directions	Quantity	Refill
Stelara	45mg/0.5ml single-use glass vial	<input type="checkbox"/> Patients weighing <100kg(200lbs) Inject 45mg SQ initially & 4 weeks later, followed by 45mg every 12 weeks. <input type="checkbox"/> Patients weighing >100kg(220lbs) Inject 90 mg (two 45mg vials)SQ initially & 4 weeks later, followed by 90mg every 12 weeks.		

Physician Signature

Date

Fax completed form to (214) 887-0436. Insurance / Clearance Questions call (214)-276-5642 or e-mail mike.ellis@ntisp.org. Pharmacy / Clinical questions (214)-276-5623 Please include the following when faxing form: Copy of insurance card(s) front & back, Pharmacy Benefit Card, lab work, letter of medical necessity, and any other supporting documentation for the drug use.
 Updated 02/09/2010

Patient's Preferred Infusion Center Location: Downtown Dallas NorthPark