Yesintek (Ustekinumab-kfce)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ Crohn's Disease	ICD-10 Code: K50.90		
☐ Ulcerative Colitis	ICD-10 Code: K51.90		
☐ Other Diagnosis:	ICD-10 Code:		

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ Confirmed negative TB testing
List Tried & Failed Therapies, including duration of treatment: 1) 2)	

MEDICATION ORDERS	
Please check box ☐ if ok to substitute with a Ustekinumab biosimilar per insurance preferred product	
Initial IV dose (choose one):	☐ Yesintek 260mg IV x1 for Weight <55kg ☐ Yesintek 390mg IV x1 for Weight 55-85kg ☐ Yesintek 520mg IV x1 for Weight >85kg
Maintenance dosing	☐ Yesintek 90mg SQ every 8 weeks ☐ Yesintek 90mg SQ every _____ weeks ☐ Office will obtain auth for SQ dosing for self administration

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

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