Provider Order Form

YESINTEK™ (ustekinumab-kfce)

Uptiv Health

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THEPATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ TB status results ☐ Hepatitis B status results

PATIENT

Full Name: DOB:

Mobile Phone: Weight: ☐ lbs ☐ kg

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Plaque Psoriasis L40. _____ ☐ Crohn's Disease K50. _____ ☐ Other: _____

☐ Psoriatic Arthritis L40. _____ ☐ Ulcerative Colitis K51. _____

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
GI Dosing:	Initial IV Dosing:	
☐ Yesintek™ (ustekinumab-kfce) Mix in 250ml 0.9% sodium chloride	☐ 260 mg ☐ 390 mg ☐ 520 mg	☐ Infuse at week 0 (loading dose)
	Maintenance SC Injection:	
	☐ 90 mg	☐ At week 8 after week 0 IV dose and every 8 weeks
Psoriasis/Psoriatic Arthritis Dosing:		☐ Induction: week 0 and 4, then every 12 weeks
☐ Yesintek™ (ustekinumab-kfce) SC Injection	☐ 45 mg ☐ 90 mg	☐ Maintenance: every 12 weeks

Refills ☐ Zero ☐ 12 months ☐ ___ Order valid for 1 year unless otherwise stated.

☒ Infuse over at least 60 minutes.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

Provider Signature Date