



Fax: 1-866-458-9245

Phone: 1-866-458-9246

E-prescribe: Exactus Pharmacy Solutions™

Stelara® is available upon prior approval through Envision. Please call 1-855-872-0005 before ordering Stelara from Exactus and using this form.

Patient Information

Name (First, MI, Last) _____ Sex ☐ M ☐ F DOB (MM/DD/YYYY) _____
Address _____ City _____
State _____ ZIP _____ Email _____
Home/Cell Phone _____ Work Phone _____ Best Contact Time _____

Insurance Information (Complete this section or provide a copy of all insurance cards Front AND Back.)

Primary Insurance _____	Secondary Insurance _____
Cardholder _____	Cardholder _____
Relationship to Cardholder _____	Relationship to Cardholder _____
Insurance Company Phone _____	Insurance Company Phone _____
Policy# _____	Policy# _____
Group# _____	Group# _____
Prescription Drug Insurer _____	Prescription Drug Insurer _____

Prescriber Information (SPECIAL NOTE: New York prescribers, please submit prescription on an original NY state prescription blank. For all other states, if not faxed, prescription must be submitted on state-specific blank, if applicable for your state.)

Prescriber Name (First, Last) _____ Specialty _____
Practice Name _____ Office Contact _____
Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Medicaid/Medicare Provider# _____ Tax ID# _____
State License# _____ UPIN/NPI# _____

Clinical Information

Primary Diagnosis ☐ 696.0 Psoriatic arthropathy ☐ 696.1 Psoriasis Comment/Other _____
Secondary Diagnosis ☐ 696.0 Psoriatic arthropathy ☐ 696.1 Psoriasis Comment/Other _____
TB Evaluation ☐ Yes ☐ No Date of Diagnosis or Years with Disease _____ Patient Weight _____
% BSA Affected _____ Prior Medications _____

Prescription Information (The prescription is only valid if received by fax.)

RX: STELARA® ☐ 45MG ☐ 90MG

Sig: Starter Doses Requested Ship Date: _____ Maintenance Therapy Requested Ship Date _____
☐ 2 single-use PF syringes; 45MG SC at Week 0 and Week 4 ☐ 1 single-use PF syringe; 45MG SC every 12 weeks Refills# _____
☐ 2 single-use PF syringes; 90MG SC at Week 0 and Week 4 ☐ 1 single-use PF syringe; 90MG SC every 12 weeks Refills# _____
Ship to (as indicated by applicable address information above): ☐ Prescriber ☐ Patient Requested Ship Date _____

Prescriber Signature (Dispense as Written) _____ DATE _____
Supervising Physician Signature (if applicable) Name _____ DATE _____