VirginiaPremier
Powered by VCU Health

exactus™
PHARMACY SOLUTIONS
Experts in pharmacy management

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 __________
Cardholder __________
Relationship to Cardholder __________
Insurance Company Phone __________
Policy# __________
Group# __________
Prescription Drug Insurer __________

Secondary Insurance __________
Cardholder __________
Relationship to Cardholder __________
Insurance Company Phone __________
Policy# __________
Group# __________
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
☐ 2 single-use PF syringes; 90MG SC at Week 0 and Week 4

☐ 1 single-use PF syringe; 45MG SC every 12 weeks Refills# __________
☐ 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 __________

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