INTRAMED Plus
infusion services

STELARA®
For Gastroenterology

INFUSION & MEDICAL CENTER

1. Patient Name ______________________ **DOB** __________ **Patient Phone/Cell #** ______________

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: ______Crohn's Disease ICD-10 Code: K50.________

______Ulcerative Colitis ICD-10 Code: K51.________

______Other: ICD-10 Code: ___________

Allergies:____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Pre-Screening Documentation
  - TB Screening Results
- Previous Drug Therapy History, including therapies trailed and or failed and date of last infusion:

❑ Remicade ❑ Orencia ❑ Humira ❑ Cimzia ❑ Other: __________ Date: ________________________

❑ Washout period of ________ weeks desired prior to the initiation of this ordered therapy

Patient
Weight: __________ lbs.
Height:___________ in.

STELARA® (ustekinumab)

4. Drug Order:

❑ **New Start**

Administer Stelara IV over 1 hour. ***Select Dose Below***

Select	Body Weight of Patient	Dose	Number of 130 mg/26 mls (5mg/ml) Stelara Vials
❑	Less than 55 kg	260 mg	2
❑	55 – 85 kg	390 mg	3
❑	Greater than 85 kg	520 mg	4

*Stelara dose will be based on the prescribing guidelines from Janssen Biotech.

❑ **Maintenance Therapy** ________ **# Refills (Recommend 3)**

Administer 90 mg Stelara subcutaneously 8 weeks after the initial infusion and every 8 weeks thereafter

(*Administered as subcutaneous injection in ambulatory infusion center after insurance approval.)

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: ___________________________ / ___________________________ Date: __________

Dispense as written Substitution permitted

Printed Physician's Name:_________________________________Contact Phone #: __________________

FAX ALL INFORMATION

CENTRAL FAX 803.794.0404

INFUSION CENTER LOCATIONS

COLUMBIA CHARLESTON GREENVILLE

CENTRAL INTAKE PHONE 800.767.6337

APR 2022