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
  - Hepatitis B Screening Results (including Hep B surface antigen)
  - 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 803.999.1754
ALTERNATE FAX 803.999.1887

INFUSION CENTER LOCATIONS
COLUMBIA CHARLESTON GREENVILLE
CENTRAL INTAKE PHONE 800.767.6337