

**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

<b>Patient Weight:</b> _____ lbs.
<b>Patient Height:</b> _____ 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
<input type="checkbox"/>	Less than 55 kg	260 mg	2
<input type="checkbox"/>	55 – 85 kg	390 mg	3
<input type="checkbox"/>	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 #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b>	<b>INFUSION CENTER LOCATIONS</b> <b>COLUMBIA CHARLESTON GREENVILLE</b> <b>CENTRAL INTAKE PHONE 803.999.1760</b>
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