

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. _____
 _____ Psoriasis, _____ ICD-10 Code: L40. _____
 _____ 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 Humria 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

Psoriasis _____ # Refills (Recommend 3)
 Administer 45 mg Stelara subcutaneously on week 0, week 4 and then every 12 weeks thereafter
 Administer 90 mg Stelara subcutaneously on week 0, week 4 and then every 12 weeks thereafter
 Crohn's Disease & Ulcerative Colitis Administer _____ mg Stelara IV over 1 hour

Maintenance Therapy

Psoriasis _____ # Refills (Recommend 3)
 Administer 45 mg Stelara subcutaneously every 12 weeks thereafter
 Administer 90 mg Stelara subcutaneously every 12 weeks thereafter
 Crohn's Disease & Ulcerative Colitis _____ # Refills (Recommend 3)
 Administer 90 mg Stelara subcutaneously 8 weeks after the initial infusion and every 8 weeks thereafter

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 #: _____

<p>FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887</p>	<p>INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960</p>
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