INTRAMED Plus
infusion services

STELARA®

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 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.

Pre-Medication Orders: ____

No Pre-medications are recommended based on manufacturer guidelines.

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**	**INFUSION CENTER LOCATIONS** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

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