

Intravene – STELARA Infusion Orders (rev 10/2018)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____ SSN _____
Height _____ Weight _____ lbs
Drug Allergies _____
 NKDA Sex: Male or Female

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address _____
Physician Phone(_____) _____
Physician Fax(_____) _____
NPI# _____ DEA# _____
State License# _____

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and this form to 434-455-5531**

DIAGNOSIS: (ICD-10 required)

Crohn's Disease

- _____
 _____ ↑

PRE TREATMENT SCREENING:

- Tuberculosis Screening: Date/Results of TB test _____
 Hepatitis B Screening: Date/ Results: _____
 Hepatitis C Screening: Date/Results: _____

Prior Medications:

Prior history:

- 5-ASA
 6-MP
 Corticosteroids
 Methotrexate
 Azathioprine
 Azulfidine
 Cyclosporin
 Other _____

Prior biologic use:

- Remicade
 Enbrel
 Humira
 Cimzia

Date of last dose:

STANDARD ORDERS:

DOSAGE AND DIRECTIONS FOR USE:

- 55 kg or less Stelara 260mg in Normal Saline 250ml over 1 hour at week 0
 more than 55 kg to 85kg Stelara 390mg in Normal Saline 250ml over 1 hour at week 0
 more than 85kg Stelara 520mg in Normal Saline 250ml over 1 hour at week 0

LABS:

- None
 Other _____

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

May discharge patient after infusion completed.

Signature, prescribing MD _____ Date: _____