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. 3001

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__________________________
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Physician Phone(_____)______________________
Physician Fax(____)_________________________
NPI#__________________DEA#_____________
State License#_______________________________

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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:	**Prior biologic use:**	**Date of last dose:**
□ **5-ASA**	□ **Remicade**	_______________
□ **6-MP**	□ **Enbrel**	_______________
□ **Corticosteroids**	□ **Humira**	_______________
□ **Methotrexate**	□ **Cimzia**	_______________
□ **Azathioprine**		_______________
□ **Azulfidine**		_______________
□ **Cyclosporin**		_______________
□ **Other**_______________		_______________

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: ________________