Stelara® IV

Provider Order Form Rev. 08/2024

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: _______ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

**ICD 10 Code Required*

☐ Crohn's Disease (K50.00-K50.919), ICD10 ___________

☐ Ulcerative Colitis (K51.00-K51.919), ICD10 ___________

☐ Other: ______________________________, ICD10 ___________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Stelara® (ustekinumab)	**INITIAL IV Dose** ☐ <55kg: 260 mg ☐ 55kg to 85kg: 390 mg ☐ >85kg: 520 mg	Infuse IV over 1 hour x 1 dose

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: ______________________________

Date of last treatment: ________________ Date of next treatment: ________________

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: ______________________________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _________ ☐ CMP q _________ ☐ CRP q _________

☐ ESR q _________ ☐ LFTs q _________ ☐ Other: _____________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________________ Date: ______________

Physician Name: ______________________ NPI: ____________ TIN: ____________ Specialty: ______________

Address: ______________________________ City/ST/Zip: ______________________

Contact Person: ______________________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

- Provide copy of TB screening (within 12 months) and must be completed annually by: ☐ Infusion Center ☐ Referring Physician
- Provide copy of Hepatitis B Screening
- Provide copy of baseline CBC, CMP and LFT

PRIOR FAILED THERAPIES (including corticosteroids, antimalarials, NSAIDS, immunosuppressants)

Medication Failed: ______________________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________________ Dates of Treatment: ______________ Reason for D/C: ______________