

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Most Recent Office Visit Note, Medication List, Insurance Information, and Recent Labs (CBC, Negative TB results)
Colonoscopy Date and Result: _____

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: L40.0 L40.50 L40.51 L40.52
 L40.53 L40.54

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

The following medications will be administered per prescribing information:

Pre-Medications: Not Usually Indicated

Center will use Hypersensitivity protocol established by Infusion for Health and P.I

MEDICATION DOSAGE:

Date of Last Treatment, If Continuation: _____

Crohn's Disease and Ulcerative Colitis:

Stelara IV x 1 Initial Dose

55kg or less: 260mg

56 kg - 85 kg: 390mg

>85 kg: 520 mg

90 mg SQ injection 8 weeks after the initial intravenous dose, then every 8 weeks thereafter.

*To ensure that a brand name product be dispensed, the prescriber must
handwrite "Brand Medically Necessary" on prescription form. If not indicated,
Infusion for Health is authorized to administer generic or biosimilar.*

Lab Orders: List: _____

Prior to first appointment Other Frequency: _____

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.