Stelara

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

☐ Home Infusion

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.