

## PATIENT INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_

## REFERRAL STATUS

New Referral       Dose or Frequency Change       Order Renewal

Is this the first dose?  Yes  No, date of last infusion: \_\_\_\_\_ Line type:  PIV  PICC  Port  Other

## DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Moderate to Severe Plaque Psoriasis	ICD-10 Code: _____
<input type="checkbox"/> Active Psoriatic Arthritis	ICD-10 Code: _____
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD-10 Code: _____
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD-10 Code: _____
<input type="checkbox"/> Other:	ICD-10 Code: _____

## REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> H&P and Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> TB Test Results	<input type="checkbox"/> Hepatitis B Test Results: HBsAg & total HepB Core antibody

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)
- 3)

## MEDICATION ORDERS

Plaque Psoriasis	<input type="checkbox"/> Stelara 45 mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight ≤ 100kg) <input type="checkbox"/> Stelara 90 mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight > 100kg)
Psoriatic Arthritis	<input type="checkbox"/> Stelara 45 mg SubQ at Week 0, 4, then every 12 weeks thereafter <input type="checkbox"/> Other: Stelara _____ mg SubQ every _____ weeks
Crohn's Disease Ulcerative Colitis	Initial IV dose (choose one): <input type="checkbox"/> Stelara 260 mg IV x1 (Weight <55kg) <input type="checkbox"/> Stelara 390 mg IV x1 (Weight 55-85kg) <input type="checkbox"/> Stelara 520 mg IV x1 (Weight >85kg) Maintenance Dosing (will start 8 weeks after IV dose, when applicable): <input type="checkbox"/> Stelara 90 mg SubQ every 8 weeks

Refills\*:  X 6 months     X 1 Year    Other: \_\_\_\_\_

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline  
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration  
 RN to flush and lock VAD/CVAD per company protocol  
 Other: \_\_\_\_\_

## EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

### Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO  
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins  
 Acetaminophen 325mg-650mg PO  
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated  
 Epinephrine 0.3mg IM/SQ, may repeat x1  
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive  
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

### Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO  
 Diphenhydramine 25mg slow IV push over 2-5 mins  
 Acetaminophen 325mg PO  
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated  
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1  
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

## PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_