Stelara® Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ○ M ○ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ○ N ○ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Crohn's Disease
_____ Ulcerative Colitis
_____ Other: _____

Please attach the following: 1. List of current Medications, including therapies trialled and or failed and date of last infusion:
○ Remicade ○ Orencia ○ Humira ○ Cimzia Date:_____
2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening:_____Washout period of _____ weeks desired prior to the initiation of this ordered therapy

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **STELARA® (ustekinumab)**

Administer Stelara IV over 30 minutes. ***Select Dose Below***

Stelara dose will be based on the prescribing guidelines from Janssen Biotech.

☐ ***New Start:***

Select	Body Weight	Dose	Number of Vials 130 mg/26 mls (5mg/ml)
☐	Less than 55 kg	**260 mg**	2
☐	55 -85 kg	**390 mg**	3
☐	More than 85 kg	**520 mg**	4

_____ # Refills (Recommend 3)

☐ ***Maintenance Dose:*** Administer 90 mg Stelara subcutaneously 8 weeks after the initial infusion and every 8 weeks thereafter
*(*Administered as subcutaneous injection in ambulatory infusion center after insurance approval.)*

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date