Stelara

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

☐ Labs (TB Test) ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ L40.50 Psoriatic Arthritis ☐ L40.0 Plaque Psoriasis ☐ K50.90 Crohn's/Pediatric Crohn's Disease

☐ K51.90 Ulcerative Colitis/Pediatric UC ☐ Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO **Diphenhydramine** (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Cetirizine (Zyrtec) ☐ 10mg PO **Methylprednisolone** (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Loratadine (Claritin) ☐ 10mg PO **Hydrocortisone** (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

☐ **No brand preference.** Health Infusion Services will select product based on payer policy. ☐ Brand preference: _____

Dose: ☐ 260mg IV ☐ 390mg IV ☐ 520mg IV **Frequency:** ☐ once (week 0)

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.