medix infusion

Stelara Order Form
(ustekinumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ______________________ DOB: ________ Phone: ______________ Sex: M F Ht: _____ Wt: _____ lbs kg

Primary Language: ______________ Allergies: ______________________________

Patient Preferred Location: ______________________________

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

K50.0 _______ Crohn's Disease, Small Intestine
K50.1 _______ Crohn's Disease, Large Intestine
K50.8 _______ Crohn's Disease, Small and Large Intestine
K50.9 _______ Crohn's Disease, Unspecified
Other: ______________________________

K51.8 _______ Other Ulcertaive Colitis, Chronic
K51.5 ________ Left Sided - Ulcerative Colitis, Chronic
K51.0 ________Universal Ulcerative Pancolitis, Chronic
K51.9 ________ Ulcerative Colitis, Unspecified

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include Negative TB within 12 months.**

PRESCRIPTION

Pre-Medications

Acetaminophen: 650 mg PO
Cetirizine: 10 mg PO
Diphenhydramine: 25 mg PO
Diphenhydramine: 25 mg IVP
Other: ________________________

Lab Orders+
Required: Negative, TB, annually

+ Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider

STELARA (ustekinumab)

Loading Dose
Dilute in total volume of 250 mL of 0.9% Sodium Chloride over at least one hour via pump using a 0.2-micron filter

IV: (wt <56 kg): Infuse 260 mg (2 vials) as a single dose
IV: (wt 56 kg - 85 kg): Infuse 390 mg (3 vials) as a single dose
IV: (wt > 85 kg): Infuse 520 mg (4 vials) as a single dose

Patient Weight: _________ lbs **or** _________ kg

Is the patient on any other disease modifying therapy? **Yes** **No**
If yes, please note therapy and last dose: ______________________

Post Treatment Observations: The patient is observed for 60 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:
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PRESCRIBER INFORMATION

Prescriber Name: ______________________ Signature: ______________________

Date: __________ NPI #: ________________ Specialty: ______________________

Supervising Physician: ______________________________________ (If Applicable)

Address: ____________________ City: ____________________ State: ________ Zip: ________

Contact Name: ______________ Phone: ____________ Fax: ____________ Email: ____________