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

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

Medication Order

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
Other: _____

Lab Orders

Requested Add'l Lab Orders:
_____
_____

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 < 55 kg): Infuse 260 mg (2 vials) as a single dose
IV: (wt 55 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

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

Comments: _____

Required Clinical Documentation

REQUIRED: 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.**

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

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____