

Outpatient Infusion Center Stelara Order

Please fax form to: 580-585-5472

Patient Information					
Patient Name:	DOB:		Phone:	Gender: M F	
Patient Address:	Email:		Insurance:		
Additional Information Needed					
Fax front/back of insurance ca		elinical/progress notes		_	
Fax patient demographics Diagnosis and Clinical Information		current medication list	Fax IB	and Hep B results	
Diagnosis (ICD-10):	Ш				
K50.00 Crohn's Disease of sm	all intestine without compli	cations			
K50.90 Crohn's Disease, Unspecified, without complications					
K51.00 Ulcerative Chronic Pancolitis without complications					
K51.90 Ulcerative Colitis, unspecified without complications					
L40.0 Psoriasis Vulgaris (moderate-to-severe plaque psoriasis) L40.50 Arthropathic Psoriasis, Unspecified					
Other: DX:	Споросинов				
Clinical Information:					
New Therapy Induction	Therap	y Change	Therap	by Continuation	
Patient Weight:lbs/	kg Patient	Height: in/	cm		
Allergies:					
Therapies Tried and Failed:Re	zente.	Hen B Test	: Date: F	Results:	
Does the patient have venous			nat type?		
If No, initiate IV access.		, ,			
Lab Orders				Lab Orders to be done by	
CBC w/o diff CMP ES	SR CRP HBsAg	HBsAB HBcAB	Quantiferon Gold	Infusion Services	
Other:				Referring Provider	
Prescription Information					
Stelara Initial Dose:	mg IV beginning week	Maintenance Dose	e: 90mg Sub-Q every	/ 8 weeks after initial week	
Weight up to 55kg = 260mg Inital Dose: 0.75mg/kg Sub-Q weeks 0, 4		Weight 55kg to 85kg = 390mg Weight >85kg = 520mg Maintenance Dose: 0.75mg/kg Sub-Q every 12 weeks after week 4			
Initial Dose: 90mg	Sub-Q weeks 0, 4	Maintenance Dose	e: 90mg Sub-Q every	/ 12 weeks after week 4	
Misc Orders					
PICC/Midline/CAD dressing to be changed every 7 da				be changed every 7 days	
Flushes 10mL NS Flush Syringe PRN					
		Heparin 500units/5mL Flush Syringe PRN 50ml NS Bag PRN			
			250ml NS Bag PRN		
Standing Orders for Adverse Rea	ection				
Stop infusion and initiate NS bo		Epi 1:100	0 1mL IM, IV or SQ f	or anaphylaxis	
Notify Supervising physician and ordering provider		Oxygen 2-5L nasal cannula			
Solu-Cortef 100mg SIVP signs of adverse reaction		Albuterol 2.5mg inhaled PRN to chest tightness			
Benadryl 25 mg SIVP for hives	or bronchial inflammation	Other:			
Prescriber Information					
Physician Name:			me:		
Contact #:		-			
Address:		_ City/State/Zip:			
NPI#:DE	EA#:	State License #:			
Physician's Signature		Date		Time	

