HEARTLAND INFUSION

Fax to Heartland (1.865.862.4556)
Questions? Call (1.865.862.4557)

# Stelara Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal **Location:** ☐ Jackson ☐ Knoxville ☐ Morristown ☐ Kingsport

## PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: (**check one**) ☐ M ☐ F

Home Phone: _____ Mobile Phone: _____

Email: _____ Last 4 of SS#: _____

Allergies: _____ Height: _____ Weight: _____

ICD-10 Diagnosis Code(s): _____ Date of Diagnosis: _____

TB Test (**circle one**): Skin Quantiferon Chest X-ray Result: _____ Date: _____

## THERAPY ORDERS

☐ IV: Administer ☐ 260mg ☐ 390mg ☐ 520mg Stelara (ustekinumab) IV THEN 8 weeks later administer 90 mg SQ every 8 weeks

☐ Administer 90 mg SQ every eight weeks OR _____

☐ Administer ☐ 0.75 mg/kg ☐ 45mg ☐ 90mg Stelara (ustekinumab) SQ at weeks 0 and 4, then every 12 weeks **THEN**

☐ Administer ☐ 0.75 mg/kg ☐ 45mg ☐ 90mg Stelara (ustekinumab) SQ every 12 weeks **OR**

(specify): _____

☐ Nursing per Heartland Nursing Procedures (include reaction management)

## PRE-MEDICATION

☐ **No routine pre-medications required**

☐ Tylenol (acetaminophen) _____mg PO

☐ Solu-Medrol (methylprednisolone) IV ☐ 40 mg, ☐ 125 mg, ☐ other _____mg

☐ Benadryl (diphenhydramine) _____mg ☐ PO ☐ IV

☐ Other: _____

☐ Zyrtec (cetirizine) 10mg PO

☐ Claritin (loratadine) 10mg PO

## LABORATORY ORDERS

| | | |
|---|---|---|
| ☐ CBC w/ DIFF | ☐ each infusion | ☐ Other: _____ |
| ☐ CRP | ☐ each infusion | ☐ Other: _____ |
| ☐ CMP | ☐ each infusion | ☐ Other: _____ |
| ☐ ESR | ☐ each infusion | ☐ Other: _____ |
| ☐ Hepatic Panel | ☐ each infusion | ☐ Other: _____ |
| ☐ Renal Panel | ☐ each infusion | ☐ Other: _____ |
| ☐ Quantiferon TB (annually) | | Due: _____ |
| ☐ Other: _____ | | |

## PRESCRIBER'S INFORMATION

Prescriber Name: _____

License #: _____ NPI: _____ DEA: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Contact: _____

Office Phone: _____ Office Fax: _____

Prescriber's Signature: _____