



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

STELARA ORDER GI

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

Indication:

K50.90 Moderate to severe Crohn's disease
 K51.90 Ulcerative Colitis
 Other _____

DRUG:

Initial Dose
 Up to 55kg 260 mg IV (2 vials)
 Greater than 55 kg to 85 kg 390 mg IV (3 vials)
 Greater than 85 kg 520 mg IV (4 vials)
 Subsequent doses:
 Patient will self-inject subsequent doses
 90mg SQ 8 weeks after IV dose then every 8 weeks
 Other _____

PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.
 Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.
 Methylprednisolone: 62.5mg IVP 125mg IVP Other _____ 30 min prior to infusion.
 Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____