hŎűƶōŜǋ 2024

Ascend

INFUSION CENTERS

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 ☐ NKDA ☐ Allergies: ____		
Height: _________________________ Weight: _________________		

Indication:

☐ K50.90 Moderate to severe Crohn’s disease
☐ K51.90 Ulcerative Colitis
☐ Other ____

DRUG:

☐ Initial IV Dose
- ☐ Up to 55kg 260 mg (2 vials)
- ☐ Greater than 55 kg to 85 kg 390 mg (3 vials)
- ☐ Greater than 85 kg 520 mg (4 vials)

☐ Subsequent doses:
- ☐ Patient will self-inject subsequent doses
- ☐ 90mg SQ 8 weeks after IV dose then every 8 weeks

☐ Other____

PREMEDICATION ORDERS: *not required by PI*

☐ Acetaminophen po:	☐ 1000mg	☐ 500mg		30 min prior to infusion.
☐ Diphenhydramine:	☐ 25mg PO	☐ 50mg PO	☐ 25mg IVP	30 min prior to infusion.
☐ Solu-Medrol:	☐ 62.5mg IVP	☐ 100mg 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 <u>ALL</u> 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: ____