Infusion ASSOCIATES®

Phone: 616-954-0600 Fax: 616-954-1675

Stelara Injection

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: □ NEW referral □ Dose or frequency change □ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

TB verification: □ **TB skin test** □ **TB spot/Quantiferon blood test** □ **Chest X-ray**

Result Date: _____/_____/_____ **Result:** □ **Positive** □**Negative**

In the past year, what medications for the above diagnosis has the patient tried and failed?
□ N/A continuation of treatment

Drug	Dose	Dates of use

Date of induction IV infusion of Stelara (if applicable):_____

Stelara (ustekinumab) Subcutaneous Injection
Dosage: _____mg

Frequency:

Initial dose :□ Week 0, 4 and THEN every 12 weeks

□ q4 wks □ q6 wks □ q8 wks □ q12 wks
□ Other: q_____wks

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:**_____