Infusion ASSOCIATES®

Phone: (833) 394-0600 Fax: (833) 996-4888

Stelara IV Infusion

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?

Drug	Dose	Dates of use

Is patient currently prescribed a different biologic medication for treatment of the above diagnosis? ☐No ☐ Yes
If yes, please list: _____

Pre-Medications:	**Diphenhydramine PO or IV**	25mg or 50mg	☐Yes ☐ No
	Cetirizine PO	10mg	☐Yes ☐ No
	Acetaminophen PO	650mg	☐Yes ☐ No
	Hydrocortisone IV	_____ mg	☐Yes ☐ No
	Drug:_____	_____mg	

Stelara (ustekinumab) IV

☐ 260 mg *(55kg or less)*

☐ 390 mg *(55-85kg)*

☐ 520mg *(more than 85 kg)*

☐ _____mg

Frequency: ☐ Once ☐ Every _____ weeks

Printed Provider Name: _____

Provider Signature: _____

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

Contact Name: _____**Contact Phone Number:** _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐TV/streaming ☐ Other: _____