

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Stelara® (ustekinumab) Standard Plan of Treatment for Gastroenterology

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:				
Patient Name:	Address:				
Date of Birth:	City, State, Zip:				
Height in inches:	Weight: LB or KG	Gender:	Allergies:	See list	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

K50.0 - Crohn's disease (small intestine)	K51.2 - Ulcerative (chronic) proctitis
K50.1 - Crohn's disease (large intestine)	K51.3 - Ulcerative (chronic) rectosigmoiditis
K50.8 - Crohn's disease (small & large intestine)	K51.5 - Left sided colitis
K50.9 - Crohn's disease, unspecified	K51.8 - Other ulcerative colitis
K51.0 - Ulcerative (chronic) pancolitis	K51.9 - Ulcerative colitis, unspecified
- Other:	

REQUESTED DOCUMENTATION:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	TB screening	THERAPY:	
6			
			Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ustekinumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

FDA labeling does not suggest premedication.

IV	Diphenhydramine	25mg	50mg	Other:	PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg			Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
				Cetirizine		10mg				
				Loratadine		10mg				
				Other:						

MEDICATION/DOSE/FREQUENCY:

Induction: Stelara® (ustekinumab) single IV dose per 250ml NS IV to infuse over at least 1 hour.

Body weight of patient	Dose
less than 55 kg	260 mg
55-85 kg	390 mg
greater than 85kg	520 mg

Maintenance: Stelara® (ustekinumab) 90 mg subcutaneously 8 weeks after initial IV and every 8

Administer as subcutaneous injection to upper arm, thigh, or abdomen.

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.



PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

Dispense as written/Brand medically necessary	Substitution permitted



Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- Patient demographics – address, phone number, SS#, etc.**
- Insurance Information – copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com