INTRAMED Plus
infusion services

STELARA®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis:
_____Crohn's Disease — ICD-10 Code: K50._____
_____Psoriasis, _____ — ICD-10 Code: L40._____
_____Ulcerative Colitis — ICD-10 Code: K51._____
_____Other: — ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes, labs, test supporting primary diagnosis
- Pre-Screening Documentation
  - Hepatitis B Screening Results (including Hep B surface antigen)
  - TB Screening Results
- Previous Drug Therapy History, including therapies trialed and or failed and date of last infusion:

❑ Remicade ❑ Orencia ❑ Humria ❑ Cimzia ❑ Other: _____ Date:_____

❑ Washout period of _____ weeks desired prior to the initiation of this ordered therapy

Patient Weight: _____ lbs.

Height:_____ in.

Drug Order:

STELARA® (ustekinumab)

4. New Start

❑ Psoriasis _____ # Refills (Recommend 3)
- ❑ Administer 45 mg Stelara subcutaneously on week 0, week 4 and then every 12 weeks thereafter
- ❑ Administer 90 mg Stelara subcutaneously on week 0, week 4 and then every 12 weeks thereafter

❑ Crohn's Disease & Ulcerative Colitis

Administer _____ mg Stelara IV over 1 hour x 1 dose

Maintenance Therapy

❑ Psoriasis _____ # Refills (Recommend 3)
- ❑ Administer 45 mg Stelara subcutaneously every 12 weeks thereafter
- ❑ Administer 90 mg Stelara subcutaneously every 12 weeks thereafter

❑ Crohn's Disease & Ulcerative Colitis _____ # Refills (Recommend 3)

Administer 90 mg Stelara subcutaneously 8 weeks after the initial infusion and every 8 weeks thereafter

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written — Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**