PREMIER VITALITY

Physician-led - Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

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: _____