OKLAHOMA INFUSION SERVICES

Stelara Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ K50.00 Crohn's Disease of Small Intestine without Complications
☐ K50.90 Crohn's Disease, Unspecified, without Complications
☐ K51.00 Ulcerative Chronic Pancolitis without Complications
☐ K51.90 Ulcerative Colitis, Unspecified, without Complications
☐ L40.0 Psoriasis Vulgaris (Moderate-to-Severe Plaque Psoriasis)
☐ L40.50 Arthropathic Psoriasis, Unspecified
☐ Other: Code: _____ Description: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold
☐ Other: _____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Stelara

☐ Initial Dose: _____ mg IV week 0 ☐ Maintenance Dose: 90mg Sub-Q every8 weeks after week 0
☐ Weight up to 55kg = 260mg ☐ Weight >55kg to 85kg = 390mg ☐ Weight >85kg = 520mg

☐ Initial Dose: 0.75mg/kg Sub-Q weeks 0, 4 ☐ Maintenance Dose: 0.75mg/kg Sub-Q every12 weeks after week 4
☐ Initial Dose: 45mg Sub-Q weeks 0, 4 ☐ Maintenance Dose: 45mg Sub-Q every12 weeks after week 4
☐ Initial Dose: 90mg Sub-Q weeks 0, 4 ☐ Maintenance Dose: 90mg Sub-Q every12 weeks after week 4

Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP ☒ Benadryl 25mg PO PRN
☒ Tylenol tablet 500-1000mg PO PRN ☐ Other: _____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus ☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Notify supervising physician and ordering provider ☒ Oxygen 2-5L nasal cannula
☒ Solu-Cortef 100mg SIVP signs of adverse reaction ☒ Albuterol 2.5mg inhaled PRN for chest tightness
☒ Benadryl 25mg SIVP for hives or bronchial inflammation ☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

_____ _____

Prescriber's Signature: Date:

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

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