

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____
DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG
ALLERGIES: _____ **PREFERRED CLINIC:** _____
REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

<input type="checkbox"/> K50.00 Crohn's Disease – small intestine	<input type="checkbox"/> K51.00 Universal Ulcerative Pancolitis – chronic
<input type="checkbox"/> K50.10 Crohn's Disease – large intestine	<input type="checkbox"/> K51.50 Left sided Ulcerative Colitis – chronic
<input type="checkbox"/> K50.80 Crohn's Disease – small & large intestine	<input type="checkbox"/> K51.80 Other Ulcerative Colitis – chronic
<input type="checkbox"/> K50.90 Crohn's Disease, unspecified	<input type="checkbox"/> K51.90 Ulcerative Colitis
<input type="checkbox"/> ICD-10 CODE: _____	DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information
 ☐ List of Medications
 ☐ Tried & Failed Therapies
 ☐ Most Recent History & Physical
 ☐ Negative TB Screening

MEDICATION ORDER
For Patients Weighing < 55 kg
☐ **INDUCTION:** Stelara® (ustekinumab) 260 mg IV in 250 ml NS over 60 minutes

For Patients Weighing 55 kg to 85 kg
☐ **INDUCTION:** Stelara® (ustekinumab) 390 mg IV in 250 ml NS over 60 minutes

For Patients Weighing > 85 kg
☐ **INDUCTION:** Stelara® (ustekinumab) 520 mg IV in 250 ml NS over 60 minutes

☐ **OTHER:** _____

*Referring provider to coordinate Sub-Q maintenance dosing with appropriate specialty pharmacy

PRE-MEDICATIONS
PO

☐ Acetaminophen: 650 mg
☐ Cetirizine: 10 mg
☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg
☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

Patient to be observed for 30 minutes following the first infusion.
 In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____
EMAIL: _____ **PHONE:** _____ **FAX:** _____
ADDRESS (INCLUDE CITY, STATE, ZIP): _____
SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)
SIGNATURE: _____ **DATE:** _____
(NO STAMPS)
 SUBSTITUTION PERMITTED DISPENSE AS WRITTEN