

# STELARA® Infusion Referral Form



University Hospitals  
Home Care Services

4510 Richmond Road  
Warrensville Heights, OH 44128  
Phone: 800-552-8442  
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

<b>Prescriber Information</b>	Prescriber: _____ NPI: _____ Phone: _____ Fax: _____ Office Contact: _____ Address: _____ _____		
<b>Patient Information</b>	Name: _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F Address: _____ Phone: _____ 2 <sup>nd</sup> Phone: _____ MRN: _____ Primary Language: _____ Functional Limitations: _____		
<b>Clinical Information</b>	Diagnosis (Include ICD-10 Code): _____ Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in IV access: <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Other: _____ Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No Prior treatments & reason for discontinuation: _____ _____ Date of <u>negative</u> TB test: _____ <input type="checkbox"/> TB test pending, will fax results. Patient is HBV negative or has been treated: <input type="checkbox"/> Yes <input type="checkbox"/> No History of kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, SCr: _____ GFR/CrCl: _____ History of heart failure: <input type="checkbox"/> Yes <input type="checkbox"/> No Additional Notes: _____ _____ _____		
<b>Prescription Information</b>	<b>Prescription Orders</b>	<b>Quantity</b>	<b>Refills</b>
	Stelara® initial IV dose: (in 250 mL NaCl 0.9% infused over at least one hour) <input type="checkbox"/> 260mg (≤55kg) <input type="checkbox"/> 390mg (56-85kg) <input type="checkbox"/> 520mg (>85kg) Supply Items: Infuse through set containing a <i>sterile, non-pyrogenic, low-protein-binding filter with pore size of 0.2µm.</i> Site of care: Home Care Infusion Center to administer IV loading dose then train patient for self-administration of SQ dosing in the home, as appropriate.	<b>1 infusion</b>	<b>Zero</b>
	Stelara® SQ Maintenance Dosing <input type="checkbox"/> Inject 90mg SQ every 8 weeks, beginning 8 weeks after IV loading dose. <input type="checkbox"/> Other regimen: _____		
	Premedication orders: _____ PRN medication orders: _____ Laboratory orders (subject to availability): _____		
<b>Prescriber Signature</b>	My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.  Signature: _____ Date: _____		

**Confidentiality statement:** This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.