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.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

_____

Patient Information

Name: _____ **DOB:** _____ ☐M ☐F

Address: _____

Phone: _____ **2nd Phone:** _____ **MRN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (Include ICD-10 Code): _____

Weight:_____ ☐lb ☐kg **Height:**_____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

Date of *negative* TB test: _____ ☐TB test pending, will fax results. **Patient is HBV negative or has been treated:** ☐Yes ☐No

History of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐Yes ☐No

Additional Notes: _____

_____

_____

Prescription Information

Prescription Orders	Quantity	Refills
Stelara® initial IV dose: (in 250 mL NaCl 0.9% infused over at least one hour) ☐260mg (≤55kg) ☐390mg (56-85kg) ☐520mg (>85kg) **Supply Items:** Infuse through set containing a ***sterile, non-pyrogenic, low-protein-binding filter with pore size of 0.2µm.*** **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.	**1 infusion**	**Zero**
Stelara® SQ Maintenance Dosing ☐Inject 90mg SQ every 8 weeks, beginning 8 weeks after IV loading dose. ☐Other regimen: _____	_____	_____

Premedication orders:_____

PRN medication orders:_____

Laboratory orders (subject to availability): _____

Prescriber Signature

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:** _____