STELARA® Infusion

OptiMed
6480 Technology Ave., Suite A | Kalamazoo, MI 49009
Phone: 877.385.0535
Fax: 877.326.2856

Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all 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:** _____ **SSN:** _____

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: _____ or ☐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

STELARA® Prescription Orders	Quantity	Refills
☐ **Initial IV dose:** ☐ 260mg (≤55kg) ☐ 390mg (56-85kg) ☐ 520mg (>85kg) in 250 mL NaCl 0.9% infused IV over at least one hour. **Supply Items:** Infuse through set containing a sterile, non-pyrogenic, low-protein-binding filter with pore size of 0.2µm. **Site of care:** OptiMed Infusion Center to administer IV loading dose.	**1 infusion**	**Zero**
☐ **Maintenance SQ dosing** ☐ Inject 90mg SQ every 8 weeks, beginning 8 weeks after IV loading dose. ☐ Other regimen _____ **Site of care:** OptiMed Infusion Center or home infusion nurse to administer Stelara SQ. Alternatively, the patient may be trained to self-administer as appropriate.	**1 dose**	_____

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 OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

V121919A

CLEAR FORM