FAX: 800-987-6552
Phone: 877-283-8679

Stelara (ustekinumab) Gastroenterology Patient Referral

PATIENT INFORMATION

Patient Name:	Ship to: ☐ Home ☐ Office		DOB:	
Home Address:	City:		State:	Zip:
Home Phone:	Height:	Weight:	Gender: ☐ Male ☐ Female	
Cell Phone:	Email Address:			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy#:	Group#:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION (fax all pertinent clinical and lab information)

Diagnosis (ICD-10):	Date of Diagnosis:	List of Failed Therapies:		
Is patient switching from other biologic therapy? ☐ Yes ☐ No	Date of last infusion:	Required washout period: _____ wks	Access: PIV ☐ PICC ☐ PORT ☐	
Negative TB Test: ☐ Yes ☐ No	Previously vaccinated against Hepatitis B or Negative HBsAg? ☐ Yes ☐ No	Recent liver function tests on file: ☐ Yes ☐ No		
List additional comorbidities:	Allergies:			

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

	Dose Based on Patient Weight	Dose	Date received, if previously administered
Stelara IV Induction/ Leading Doses	up to 55 kg	260 mg (2 x 130mg/26mL vials)	
	greater than 55kg to 85kg	390 mg (3 x 130mg/26mL vials)	
	greater than 85kg	520 mg (4 x 130mg/26mL vials)	
Stelara Subcutaneous Maintenance Dose	90 MG (2 x 45mg/0.5mLvials) subcutaneously once every 8 weeks.		

	Pre-Medications: administered 30 minutes prior to infusion.	**IV Flushing Protocol:**
Pre-Medications and Flushing Protocol for IV Induction Dose Only	☐ Diphenhydramine _____mg ☐ PO or ☐ IV	☐ Sodium Chloride 0.9% 5-10 mL pre and post medication and prn
	☐ Acetaminophen _____mg PO	☐ Heparin 10 u/ml Peripheral Line: 3 ml after last NaCl 0.9% flush and prn
	☐ OTHER: _____	☐ Heparin 100 u/ml Central Line: 5ml after last NaCl 0.9% flush and prn

Refill for Subcutaneous Maintenance Dose: **PRN x 1 year (OR _____ times)**

Anaphylaxis Orders and Medications	☐ Provide anaphylaxis kit per pharmacy protocol.
Pump and Ancillary Supplies	☐ Provide pump and supplies as needed for dilution, administration, and appropriate disposal of infusion materials.
Skilled Nursing Orders and Plan of Treatment	☐ Provide skilled nursing for home infusion of IV induction dose, and for training of self-injection maintenance dose.
	☐ In-office IV induction dose infusion; no nursing administration or education needed.

Administration procedures to be followed per pharmacy protocol or manufacturer's guidelines.

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email Address:	
Address:		
NPI:		

Prescriber Signature: Date:

Your signature authorizes AvevoRx, LLC and their network of pharmacies, Mid-Valley Health System (the "AvevoRx Pharmacies"), to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

***Referral forms are not considered legal prescriptions for certain payers and in certain states, including AL. AvevoRx, or it's partner pharmacies may request additional prescription orders where required by local state Board of Pharmacy regulations or specific payer restrictions.