



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

## Stelara (ustekinumab) Gastroenterology Patient Referral

### PATIENT INFORMATION

Patient Name:	Ship to: <input type="checkbox"/> Home <input type="checkbox"/> Office	DOB:
Home Address:	City:	State: <span style="float: right;">Zip:</span>
Home Phone:	Height:	Weight: <span style="float: right;">Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</span>
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of last infusion: _____ Required washout period: _____ wks
Negative TB Test: <input type="checkbox"/> Yes <input type="checkbox"/> No		Previously vaccinated against Hepatitis B or Negative HBsAg? <input type="checkbox"/> Yes <input type="checkbox"/> No
List additional comorbidities:		Recent liver function tests on file: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies:		Access: PIV <input type="checkbox"/> PICC <input type="checkbox"/> PORT <input type="checkbox"/>

### PRESCRIPTION INFORMATION (or attach a copy of the prescription)

	Dose Based on Patient Weight	Dose	Date received, if previously administered
<b>Stelara IV Induction/ Leading Doses</b>	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)	

<b>Stelara Subcutaneous Maintenance Dose</b>	90 MG (2 x 45mg/0.5mLvials) subcutaneously once every 8 weeks.
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<b>Pre-Medications and Flushing Protocol for IV Induction Dose Only</b>	Pre-Medications: administered 30 minutes prior to infusion.	IV Flushing Protocol:
	<input type="checkbox"/> Diphenhydramine _____mg <input type="checkbox"/> PO or <input type="checkbox"/> IV	<input type="checkbox"/> Sodium Chloride 0.9% 5-10 mL pre and post medication and prn
	<input type="checkbox"/> Acetaminophen _____mg PO	<input type="checkbox"/> Heparin 10 u/ml Peripheral Line: 3 ml after last NaCl 0.9% flush and prn
	<input type="checkbox"/> OTHER: _____	<input type="checkbox"/> 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)**

<b>Anaphylaxis Orders and Medications</b>	<input type="checkbox"/> Provide anaphylaxis kit per pharmacy protocol.
<b>Pump and Ancillary Supplies</b>	<input type="checkbox"/> Provide pump and supplies as needed for dilution, administration, and appropriate disposal of infusion materials.
<b>Skilled Nursing Orders and Plan of Treatment</b>	<input type="checkbox"/> Provide skilled nursing for home infusion of IV induction dose, and for training of self-injection maintenance dose.
	<input type="checkbox"/> 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.

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\*\*\*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.