Ustekinumab (Stelara with biosimilar substitution allowed) Infusion Order Form

PACE HEALTHCARE LLC

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners. _____

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone #: _____ Contact Fax #: _____

NPI / TIN: _____ _____

INITIAL DOSE ORDER *(To be administered in office only. Not for self or home injection)*

Patient Weight (kg): _____ Initial IV infusion strength: ☐ 260mg ☐ 390mg ☐ 520mg

PREMEDS: ☐ Benadryl (Diphenhydramine) ☐ Oral 25mg ☐ Oral 50mg ☐ IV 50mg
☐ Acetaminophen (Tylenol) ☐ 325mg ☐ 650mg

MAINTENANCE DOSE ORDERS *(To be administered in Ambulatory Infusion Suite)*

Patient Weight (kg): _____ SubQ injection strength: ☐ 45mg ☐ 90mg ☐ other _____

SubQ injection frequency: ☐ Every 8 weeks ☐ Every 12 weeks

INDICATION/DIAGNOSIS

☐ K50.90 Crohn's disease, unspecified, without complications
☐ K51.90 Ulcerative colitis, unspecified, without complications
☐ Other *(please specify in notes)*

NOTES (ADDITIONAL INFO)

***ICD-10 _____ required**

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ PPD Results (w/in 12 months)

☐ Chest X-ray (if indicated) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY