STELARA Infusion Referral Order Form (Dermatology)

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 / DEA#: _____ _____

STELARA IN OFFICE (Dermatology)

Patient Weight (kg):_____ Sub-Q Injection in Office: ☐ 45mg ☐ 90mg ☐ other _____

To be administered in office only. Not for self or home injection.

Frequency: ☐ **Induction dose: Week 0 & 4** ☐ **Maintenance dose: Every 12 weeks**

Premeds: ☐ Benadryl ☐ APAP ☐ Diphenhydramine ORAL: ☐ 25mg ☐ 50mg
Acetaminophen (tylenol) ☐ 325mg ☐ 650mg

INDICATION/DIAGNOSIS

☐ Psoriatic Arthritis
☐ Psoriasis
☐ Ulcerative colitis, unspecified, without complications
☐ Crohn's Disease ☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____
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