STELARA Infusion Referral Order Form

FAX (877) 428-7248

WWW.CURBSIDEINFUSION.COM
PH: 877-428-7248 FAX: 877-428-1627

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

PATIENT INFORMATION

Name: ______________________ Date: ________

DOB: ______________ SS# ______________

Phone # ________________

Email: ____________________________________

PHYSICIAN INFORMATION

Referring Physician: ______________________________

Practice Address: ______________________________

____

Office Contact: ______________________________

Contact Phone #: __________ Contact Fax #: __________

NPI / DEA#: ______________ ______________

STELARA IN OFFICE (AIS)

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 ☐ Every 8 weeks ☐ Every 12 weeks REFILLS: __________

STELARA MEDICATION ORDERS

Patient Weight:_______ Initial IV infusion: ☐ 260mg ☐ 390mg ☐ 520mg

Premeds: ☐ Benadryl ☐ APAP ☐ Diphenhydramine ORAL: ☐ 25mg ☐ 50mg IV: ☐ 50mg

Acetaminophen (Tylenol) ☐ 325mg ☐ 650mg

INDICATION/DIAGNOSIS

☐ Psoriatic Arthritis
☐ Psoriasis
☐ 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

01/2021