



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION			
Primary ICD-10 Code (Please Specify Diagnosis): _____ Secondary ICD-10 Code (Please Specify Diagnosis): _____ Date of negative TB test: _____ <input type="checkbox"/> TB test still pending, will fax results Has patient received Hepatitis B vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Line Access: <input type="checkbox"/> PIV <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Midline **Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
STELARA® ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Dose/Frequency		Quantity/Refills
<input type="checkbox"/> Stelara® (ustekinumab) IV	<input type="checkbox"/> ≤ 55kg 260mg IV as a single dose. <input type="checkbox"/> > 55kg to 85kg 390mg IV as a single dose. <input type="checkbox"/> > 85kg 520mg IV as a single dose. <input type="checkbox"/> Other: _____ <input type="checkbox"/> Frequency: _____		Quantity: _____ Refills: _____
<input type="checkbox"/> Stelara® (ustekinumab) Subcutaneous	<input type="checkbox"/> 90mg every 8 weeks, starting 8 weeks after infusion <input type="checkbox"/> Other: _____ <input type="checkbox"/> Frequency: _____		Quantity: _____ Refills: _____
Pre-Medication	Dose/Strength	Directions	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take by mouth prior to each infusion	
<input type="checkbox"/> Cetirizine	<input type="checkbox"/> 10mg	<input type="checkbox"/> Take by mouth prior to each infusion	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	<input type="checkbox"/> Take by mouth prior to each infusion <input type="checkbox"/> Administer via IV prior to each infusion	
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Administer via IV prior to each infusion <input type="checkbox"/> Other: _____	
<input type="checkbox"/> _____	_____	_____	

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**ANAPHYLACTIC REACTION (AR):**

- ☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh  $\geq 66$  lbs ( $\geq 30$  kg); may repeat in 3-5 mins x 1 if necessary
- ☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary
- ☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary
- ☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access
- ☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr
- ☐ Other: \_\_\_\_\_

**SIGNATURE**

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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