Wells Infusion Centers

STELARA ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: _____

Patient Information

Patient Name: DOB: Sex: ☐ M ☐ F

Address: Phone: Email:

Height (in): Weight (lb): Referral Status: ☐ New ☐ Updated ☐ Renewal

Infusion/ Injection Information

Primary ICD-10 Code: Primary ICD-10 Description:

Other ICD-10 Codes: Other ICD-10 Descriptions:

Stelara (Ustekinumab) Dosing Info:

- ☐ ≤ 55kg 260mg intravenously (IV) - single dose
- ☐ > 55kg to 85kg 390mg IV - single dose
- ☐ > 85kg 520mg IV - single dose

Premedications:

- ☐ _____
  _____

Required Documentation:

- ☐ Full Patient Chart
- ☐ Insurance Cards (Front and Back)
- ☐ Clinical Notes Supporting Diagnosis
- ☐ List of Current Medications, Conditions, and Allergies
- ☐ TB Test Results within 6 months

Ordering Provider Information

Practice Name: Practice Phone: Practice Fax:

Practice Address: Referral Coordinator Name:

Referral Coordinator Email: Referral Coordinator Phone:

Ordering Provider: Provider NPI: Specialty:

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

_____ Provider Name

_____ Provider Signature

_____ Date

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL 570-4INFUSE (570-446-3873) OR EMAIL INFO@WELLSINFUSION.COM