Stelara Enrollment Form

Date:
Patient Name: _____
Date of Birth: _____
_____

TwelveStone Health Partners

Fax Referral To:
(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last infusion date: _____ Next infusion date: _____	☐ Physician's office TwelveStone Infusion Center ☐ Canton ☐ Chattanooga ☐ Knoxville ☐ Mount Juliet ☐ Murfreesboro ☐ Other: _____ Desired start date: _____

DIAGNOSIS

Description	*ICD-10 Code*
☐ Crohn's Disease ☐ Psoriasis ☐ Psoriatic Arthritis ☐ Ulcerative Colitis	☐ K50 ☐ L40.9 ☐ L40.5 ☐ K51 ☐ Other: _____

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

☐ This signed order form ☐ History and Physical

☐ Patient Demographics and Insurance Information ☐ Clinical progress notes, baseline lab work indicated below, and any other tests or documentation supporting primary diagnosis

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg/Lbs Height: _____ Inches/CM BSA: _____ Allergies: _____

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size _____ Gauge _____ Length _____) ☐ SubQ

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to Draw)
☐ Stelara	☐ Initiation - Infuse [ ] <55kg 260mg, [ ] 55kg-85kg 390mg; [ ] >85 kg 520 mg IV over 60 minutes x 1 dose ☐ Maintenance - Inject 90 mg SQ 8 weeks after initial dose and every 8 weeks thereafter ☐ Initiation - (< or = 100kg) - Inject 90 mg SQ on weeks 0 and 4, and every 12 weeks thereafter ☐ Maintenance - (< or = 100kg) - Inject 45 mg SQ 12 weeks ☐ Initiation - (> or = 100kg) - Inject 90m mg SQ on weeks 0 and 4, and every 12 weeks thereafter ☐ Maintenance(> or = 100kg) - Inject 90m mg SQ every 12 weeks		☐ CBC w/ Differential ☐ TB QuantiFERON Gold

LAB ORDERS

Order	Frequency			
CBC w/ Differential	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
CBC w/o Differential	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
CMP	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
BMP	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
CRP	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
Sed Rate	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
Calcium	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
Tb QuantiFERON Gold	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
Hepatitis Panel	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____
Other: _____	☐ One time prior to treatment	☐ Every treatment	☐ Q ____ weeks	☐ Other: _____

Pre-medications - *Recommended - Check here for NO pre-meds _____

Oral	IV
* Acetaminophen: [ ] 325mg [ ]500mg [ ] 650mg Cetirizine: [ ] 10mg Diphenhydramine: [ ] 25mg [ ] 50mg Famotidine: [ ] 20mg [ ] 40mg Ibuprofen: [ ] 200mg Loratidine: [ ] 10mg Ondansetron: [ ] 4mg	Dexamethasone: [ ] 4mg [ ] 8mg Diphenhydramine: [ ] 25mg [ ] 50mg Famotidine: [ ] 20mg [ ] 40mg Methylprednisolone: [ ] _____ mg IV over _____ mins Ondansetron: [ ] 4mg [ ] 8mg Other [ ] _____

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone: _____ Physician's NPI#: _____ Physician's Fax# : _____ Physician's Address: _____

Dispense as Written: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

v1.5.22