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:

Last infusion date: ____________________

Next infusion date: ____________________

If NO, please indicate desired location for first dose:

☐ Physician's office

TwelveStone Infusion Center

☐ Canton ☐ Chattanooga ☐ Knoxville ☐ Mount Juliet ☐ Murfreesboro

☐ Other: ____________________

Desired start date: ____________________

DIAGNOSIS

Description

☐ Crohn's Disease ☐ Psoriasis ☐ Psoriatic Arthritis ☐ Ulcerative Colitis

ICD-10 Code

☐ 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		☐ CBC w/ Differential
	☐ Maintenance - Inject 90 mg SQ 8 weeks after initial dose and every 8 weeks thereafter		☐ TB QuantiFERON Gold
	☐ 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		

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	Dexamethasone: [ ] 4mg [ ] 8mg
Cetirizine: [ ] 10mg	Diphenhydramine: [ ] 25mg [ ] 50mg
Diphenhydramine: [ ] 25mg [ ] 50mg	Famotidine: [ ] 20mg [ ] 40mg
Famotidine: [ ] 20mg [ ] 40mg	Methylprednisolone: [ ] _____ mg IV over _____ mins
Ibuprofen: [ ] 200mg	Ondansetron: [ ] 4mg [ ] 8mg
Loratidine: [ ] 10mg	Other [ ] ____________________
Ondansetron: [ ] 4mg	

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

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