



Birmingham, AL
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Huntsville, AL
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Knoxville, TN
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Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
 Phone Number: _____ Email Address: _____
 Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
 Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Crohn's Disease
 _____ Ulcerative Colitis
 _____ Other: _____

Please attach the following: 1. List of current Medications, including therapies trialled and or failed and date of last infusion:

Remicade Orenzia Humira Cimzia Date: _____

2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening: _____ Washout period of _____ weeks desired prior to the initiation of this ordered therapy

Physician Information

Prescribing Physician: _____ Practice Name: _____
 Practice Phone: _____ Practice Fax: _____
 Email: _____ Office Contact: _____
 Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: STELARA® (ustekinumab)

Administer Stelara IV over 30 minutes. ***Select Dose Below***

Stelara dose will be based on the prescribing guidelines from Janssen Biotech.

New Start:

Select	Body Weight	Dose	Number of Vials <small>130 mg/26 mis (5mg/ml)</small>
	Less than 55 kg	260 mg	2
	55 -85 kg	390 mg	3
	More than 85 kg	520 mg	4

_____ # Refills (Recommend 3)

Maintenance Dose: Administer 90 mg Stelara subcutaneously 8 weeks after the initial infusion and every 8 weeks thereafter

*(*Administered as subcutaneous injection in ambulatory infusion center after insurance approval.)*

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

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

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI#

Physician's Address

Prescriber's Signature

Date