TEXASINFUSION

1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-7987
Fx: 972-787-1492

STELARA INFUSION FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Patient Weight = _____kg; Height _____inches

DIAGNOSIS AND ICD 10 CODE	
☐ Chron's Disease	ICD 10 Code: _____
☐ Ulcerative Colitis	ICD 10 Code: _____
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Annual TB- Quantiferon TB gold OR neg. chest X-ray
☐ Face sheet and Insurance card	☐ Labs: CBC w/ diff and LFT's
☐ Clinical/Progress notes	☐ Other:_____

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

PA Guidance: Failed Steroids, NSAID, MTX, leflunomide. Failed injectable biologics: Humira, Cimzia, Infliximab,

ORDERS	
Induction Dose: added to 250ml 0.9% Normal Saline soln for IV infusion.	☐ ≤55kg (<121 lbs.) 260mg (or _____mg) IV over 1 hour x 1 dose ☐ >55kg to 85kg (121 lbs. to 187 lbs.) 390mg IV over 1 hour x 1 dose ☐ Normal saline Flushes 10ml as needed (max 10 per infusion) ☐ PREMEDS: _____
Infusion orders	☐ Nurse to start, pause, or discontinue peripheral or central venus access device PRN ☐ Flush IV line with 10-20ml saline before and after each medication dose or as needed ☐ Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed ☐ Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 1L 0.9% NS)	
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:	NPI #:	
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 1-2-2023