STELARA® Infusion



Phone: 877.385.0535 Fax: 877.326.2856

6480 Technology Ave., Suite A | Kalamazoo, MI 49009

| Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of <u>all</u> the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents. | | | |
|--|---|------------------------|--|
| Prescriber Information | Prescriber: NPI: | | |
| | Phone: | | |
| | Address: | | |
| Patient Information | | | |
| | Name: DOB: | | |
| | Address: | | |
| | Phone: SSN | l: | |
| | Primary Language: Functional Limitations: | | |
| Clinical Information | Diagnosis (include ICD-10 code): | | |
| | Weight: □ Ib □ kg Height: □ in IV access: □ PIV □ PICC □ Port □ Other: | | |
| | Allergies:Latex allergy? Yes No | | |
| | Prior treatments & reason for discontinuation: | | |
| | Prior treatments & reason for discontinuation. | | |
| | Data of nagative TP toots | | |
| | Date of <u>negative</u> TB test: or □TB test pending, will fax results. Patient is HBV negative or has been treated: □Yes □No | | |
| | History of kidney disease: □Yes □No If yes, SCr: GFR/CrCl: History of heart failure: □Yes □No | | |
| | Additional Notes: | | |
| | | | |
| 1 j | | | |
| | | | |
| | STELARA® Prescription Orders | Quantity | Refills |
| | □ Initial IV dose: | Quantity | Refills |
| | • | Quantity | Refills |
| | ☐ Initial IV dose: ☐ 260mg (≤55kg) ☐ 390mg (56-85kg) ☐ 520mg (>85kg) in 250 mL NaCl 0.9% infused IV over at least one hour. | Quantity 1 infusion | Refills Zero |
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