

**LAWRENCE COUNTY**  
**Memorial  Hospital**  
**DEACONESS ILLINOIS PARTNER**

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:
REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal	
DIAGNOSIS AND ICDE 10 CODE	
<input type="checkbox"/> Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
<input type="checkbox"/> Active Psoriatic Arthritis	ICD 10 Code: L40.52
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
<input type="checkbox"/> Other: _____	ICD 10 Code: _____
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)	
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number  *Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year)\ <input type="checkbox"/> Labs and tests supporting primary diagnosis <input type="checkbox"/> TB Test results <input type="checkbox"/> Hepatitis B results: ABsAg, & HepB Core w/reflex IgG and IgM
List of tried and failed therapies, including duration of treatment: _____	
MEDICATION ORDERS	
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____	
Plaque Psoriasis Dosing	<input type="checkbox"/> J3358 Stelara 45mg SubQ at week 0, 4, then every 12 weeks thereafter (weight ≤ 100kg) <input type="checkbox"/> J3358 Stelara 90mg SubQ at week 0, 4, then every 12 weeks thereafter (weight > 100kg)
Psoriatic Arthritis Dosing	<input type="checkbox"/> J3358 Stelara 45mg SubQ at week 0, 4, then every 12 weeks thereafter <input type="checkbox"/> J3358 Stelara _____ mg SubQ _____
Crohn's Disease and Ulcerative Colitis Dosing	<u>Initial IV dose (choose one)</u> <input type="checkbox"/> Stelara 260mg IV x1 for weight < 55kg <input type="checkbox"/> Stelara 390mg IV x1 for weight 55-85kg <input type="checkbox"/> Stelara 520mg IV x1 for weight >85kg  <u>Maintenance Dosing (will start 8 weeks after IV dose, when applicable)</u> <input type="checkbox"/> Stelara 90mg SubQ every 8 weeks
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses	
PREMEDICATIONS/ LAB ORDERS	
<input type="checkbox"/> Acetaminophen _____ mg PO PRN <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> Methylprednisolone _____ slow IV push <input type="checkbox"/> Other: _____	<input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Other: _____ Date: _____
ADDITIONAL ORDERS/INFORMATION	
PRESCRIBER INFORMATION	
Provider Name:	
Office Phone:	Office Fax:
Office Email:	Date: _____ Time: _____
Prescriber Signature:	

ALL INFORMATION CONTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD. CONTACT US WITH QUESTIONS AT 618-943-8515... FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

**INFUSION ORDERS – STELARA (USTEKINUMAB)**