



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION
Primary ICD-10 Code (Please Specify Diagnosis): _____
Secondary ICD-10 Code (Please Specify Diagnosis): _____
Date of negative TB test: _____ <input type="checkbox"/> TB test still pending, will fax results Has patient received Hepatitis B vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Line Access: <input type="checkbox"/> PIV <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Midline

STELARA® ORDERS
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Quantity/Refills
<input type="checkbox"/> Stelara® (ustekinumab) IV	<input type="checkbox"/> ≤ 55kg 260mg IV as a single dose. <input type="checkbox"/> > 55kg to 85kg 390mg IV as a single dose. <input type="checkbox"/> > 85kg 520mg IV as a single dose. <input type="checkbox"/> Other: _____ <input type="checkbox"/> Frequency: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Stelara® (ustekinumab) Subcutaneous	<input type="checkbox"/> 90mg every 8 weeks, starting 8 weeks after infusion <input type="checkbox"/> Other: _____ <input type="checkbox"/> Frequency: _____	Quantity: _____ Refills: _____

Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Cetirizine	<input type="checkbox"/> 10mg	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion
<input type="checkbox"/> _____	_____	_____

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SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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