Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: ______________________________ Patient D.O.B.__________________________

Current Height: __________________________ Current Weight__________________________

Patient Phone # (_____) ______-_______________ Gender______________________

Patient Address ____

City________________ State ______________ Zip Code________________________

Related Diagnosis Code (ICD-10 code): ____

Referring Provider (Please Print) ____

Office Phone # (_____) ______-_______________ Office Contact: __________________________

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Stelara® (Ustekinumab) Gastroenterology Treatment Plan

Patient Name: ____________________________________ **Patient DOB** ______________________________

Diagnosis- ________________________________ ICD-10 Code _______________________________

Pt. Weight ______________ Pt Height ______________ Known Allergies ______________

Requested Start Date ____/____/_______

Has patient previously received this medication:

☐ No ☐ Yes, if so, date of last infusion ____/____/_______ and number of previous infusions ________

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)
every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP and prior to discharge

<u>Induction Dose Stelara (ustekinumab)</u> – 1x Infusion

☐ *260mg, IV Piggyback, Powder-Inj, Day of Tx [**Less Than or equal to 55.0 kg]***
Comments: Mix in NS 250 mL. Infuse over 60 minutes. Infuse using in-line, low protein binding 0.2 micron filter.

☐ *390mg, IV Piggyback, Powder-Inj, Day of Tx [**Greater Than 55.0 kg to 85.0 kg]***
Comments: Mix in NS 250 mL. Infuse over 60 minutes. Infuse using in-line, low protein binding 0.2 micron filter.

☐ *520mg, IV Piggyback, Powder-Inj, Day of Tx [**Greater Than 85.0 kg]***
Comments: Mix in NS 250 mL. Infuse over 60 minutes. Infuse using in-line, low protein binding 0.2 micron filter.

☑ Communication Order (Month 1 to 12)
Ensure negative PPD or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ Quantiferon(R)-TB Gold, 4T, Incu-(36971) (If Needed)

☑ Other: ____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _________________________ Provider Name (please print)_________________________

Date_____/_____/__________