



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION		
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: ☐ M ☐ F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____		
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)				
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		
CLINICAL INFORMATION				
Primary ICD-10 Code (Please Specify Diagnosis): _____ Secondary ICD-10 Code (Please Specify Diagnosis): _____ Date of negative TB test: _____ ☐ TB test still pending, will fax results Has patient received Hepatitis B vaccine? ☐ Yes ☐ No Is patient currently on therapy? ☐ Yes ☐ No Line Access: ☐ PIV ☐ Port ☐ PICC ☐ Midline				
STELARA® ORDERS				
Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____				
Medication		Dose/Frequency		
☐ Stelara® (ustekinumab) IV		☐ ≤ 55kg 260mg IV as a single dose. ☐ > 55kg to 85kg 390mg IV as a single dose. ☐ > 85kg 520mg IV as a single dose. ☐ Other: _____ ☐ Frequency: _____		Quantity: _____ Refills: _____
☐ Stelara® (ustekinumab) Subcutaneous		☐ 90mg every 8 weeks, starting 8 weeks after infusion ☐ Other: _____ ☐ Frequency: _____		Quantity: _____ Refills: _____
Pre-Medication		Dose/Strength		
☐ Acetaminophen		☐ 500mg		
☐ Diphenhydramine		☐ 25mg IV/PO ☐ 50mg IV/PO		
☐ Methylprednisolone		☐ 40mg ☐ 100mg ☐ 125mg		
☐ _____		_____		
Directions				
☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed				
☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed				
☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion				
☐ _____				
INFUSION REACTION ORDERS				
Mild reaction protocol:				

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☒ Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mid-antergluteal aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:

☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:

☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:

☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

PICC:

☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:

☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

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 _____

Prescriber Signature

Date: _____

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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