TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

Stelara® Referral Form

Return Completed Form To:
888.898.9113

PATIENT INFORMATION (Complete or fax existing chart)			PRESCRIBER INFORMATION	
Patient Name:			Prescriber Name:	
Address:			State License:	NPI#:
City, State, Zip:			DEA:	Phone:
Phone:	2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ Female		City, State, Zip:	
Weight:	Ht:	Allergies:	Contact Person:	Phone:

INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)			
Primary Insurance:		RX Card (PBM):	
City, State, Zip:		BIN:	PCN:
Plan#	Group#	City, State, Zip:	
Phone:		Plan#	Group#

DIAGNOSIS

☐ **Adult with moderate to severe Plaque Psoriasis** - ICD Code(s): _____
☐ **Adult with active Psoriatic Arthritis -** ICD Code(s): _____
☐ **Adult with moderately to severely active Crohn's Disease** – ICD Code(s): _____
☐ **Adult with moderately to severely active Ulcerative Colitis** – ICD Code(s): _____
☐ **Age 6 years – 18 years with moderate to severe Plaque Psoriasis** – ICD Codes (s):_____
☐ **Age 6 years -18 years with active Psoriatic Arthritis** – ICD Code(s): _____
☐ **Other** – ICD Code(s):_____

ONE-TIME IV INDUCTION DOSING: (For use with Adult Crohn's Disease and Ulcerative Colitis only)

Patient previously received induction dose: Yes☐ No☐ Date of infusion: _____ Induction dose:_____

Patient weight:_____
☐ 55 kg or less: 260 mg (2 x 130 mg/26 mL vials) at Week 0:
☐ more than 55 kg to 85 kg: 390 mg (3 x 130 mg/26 mL vials) at Week 0:
☐ more than 85 kg: 520 mg (4 x 130 mg/26 mL vials) at Week 0:

REQUIRED PRE- TREATMENT EVALUATION:

Tuberculosis Screening:
☐ **Complete** – Negative Results Attached and patient may proceed with therapy
☐ **Complete** – Positive Results Attached – TB treatment initiated – Must complete adequate course of therapy prior to proceeding with therapy
☐ **In Process** – Results Pending

OPTIONAL PREMEDICATIONS

☐ Acetaminophen 500 mg	☐ Acetaminophen 1000 mg
☐ Diphenhydramine 25 mg PO	☐ Zyrtec 10 mg PO
☐ Diphenhydramine 25 mg IV	☐ Famotidine 20mg IV
☐ Solu-Medrol 125 mg SIVP	

SUBCUTANEOUS PRESCRIPTION INFORMATION

Patient Weight _____ kg	**Dosing:**	**Interval:**
	☐ 90mg single-dose prefilled syringe for subcutaneous injection	☐ Initial does ☐ 4 weeks later ☐ 8 weeks later ☐ every 8 weeks ☐ every 12 weeks
	☐ 45mg single-dose prefilled syringe for subcutaneous injection	☐ Initial does ☐ 4 weeks later ☐ 8 weeks later ☐ every 8 weeks ☐ every 12 weeks
	☐ 45mg single-dose vial for subcutaneous injection	☐ Initial does ☐ 4 weeks later ☐ 8 weeks later ☐ every 8 weeks ☐ every 12 weeks
	☐ 0.75mg/kg = _____mg	☐ Initial does ☐ 4 weeks later ☐ 8 weeks later ☐ every 8 weeks ☐ every 12 weeks

SIGNATURE

x Date:
(Product Substitution Permitted)