Stelara®
Referring Physician Orders Rev. 4/2026
Please fax completed referral form & all required documents to 770-618-9617

CPS | INFUSION

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: ______________________ DOB: ______________ Phone: ______________
Address: ______________________ City/St/Zip: ______________________
Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: ________ ☐ in ☐ cm

DIAGNOSIS*

ICD-10 CODE *(required)* ***Please complete 2nd and 3rd digits to complete ICD-10 for billing***

☐ K50.0 _____ Crohn's Disease of Small Intestine without Complications
☐ K50.1 _____ Crohn's Disease of Large Intestine without Complications
☐ K50.8 _____ Crohn's Disease of Both Small and lg Int w/o Complications
☐ K51.0 _____ Ulcerative (Chronic) Pancolitis without Complications
☐ K51.2 _____ Ulcerative (Chronic) Proctitis without Complications
☐ Other: ______________________, ICD-10 ________

INFUSION ORDERS

MEDICATION	INITIAL IV DOSE	DIRECTIONS/DURATION
Stelara® (natalizumba)	☐ <55kg – 260mg ☐ >85kg – 520mg ☐ >85kg – 520mg	☐ Infuse IV over 1 hour x 1 dose

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES
If yes, Facility Name: ______________________ Date of last treatment: ____________ Date of next treatment: ____________

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician
☐ No labs ordered at this time
☐ CBC q _________ ☐ CMP q _________ ☐ CRP q _________ ☐ ESR q _________ ☐ LFTs q _________ ☐ Other: _________

PRE-MEDICATION ORDERS:
☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV
☐ Other: ______________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________
Physician Name: ______________________ Provider NPI: ______________ Specialty: ______________
Address: ______________________ City/ST/Zip: ______________________
Contact Person: ______________________ Phone #: ______________ Fax #: ______________
Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS *(required)*

- TB Screening for Cimzia, Entyvio, infliximab biosimilars, Omvoh, Skyrizi, Stelara and Tremfya (submit results from within 12 months to start and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening for Cimzia and infliximab biosimilars (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by: ☐ Infusion Center ☐ Referring Physician

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
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