

(ustekinumab)

STELARA IV infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ ☐ Allergies M ☐ F ☐

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

- ☐ New Prescription
- ☐ Order Renewal
- ☐ Does or Frequency Change
- ☐ Discontinuation

DIAGNOSIS Please provide ICD-10 code

☐ _____ Crohn's Disease

☐ _____
(other)

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____

- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

STELARA INTRAVENOUS ORDERS

DOSAGE

- ☐ up to 55kg - **260mg** (2 vials)
- ☐ greater than 55kg to 85kg - **390mg** (3 vials)
- ☐ greater than 85kg - **520mg** (4 vials)
- ☐ Other _____

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

- ☐ initial infusion followed by SQ injections self-administered
(follow-up maintenance injections to be coordinated by a specialty pharmacy and are not part of this order)

Route: ☐ IV ☐ SQ

☐ Total dosages _____

☐ Refills _____

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____