☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

☐ *Long Beach*
917 Beech Street
Long Beach, NY 11561

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

(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

◯ Total dosages _____
◯ Refills _____

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

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____