

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076



(ustekinumab)

STELARA IV infusion orders

 Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

_____ Chron's Disease

_____ (other)

PRE-MEDICATION

<input type="checkbox"/> Tylenol 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP
<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP

_____ (other) _____ (other)

STELARA IV ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE:

<input type="checkbox"/> up to 55kg-	260mg (2 vials)
<input type="checkbox"/> greater than 55kg to 85kg -	390mg (3 vials)
<input type="checkbox"/> greater than 85kg -	520mg (4 vials)

Other _____

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/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____