(ustekinumab)

STELARA IV infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

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
☐ _____

☐ Length of Need _____

STELARA IV ORDERS

DOSAGE

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

PATIENT WEIGHT

_____ lbs.
_____ kg

FREQUENCY

◯ Refills: _____

◯ 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)

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887