

NPI# _____
DEA# _____

FAX ORDERS: 702-697-2107



(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

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

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: _____
