

Los Angeles, CA  
2080 Century Part East  
Suite 710  
Los Angeles, CA 90067



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