

Pensacola
41 Fairpoint Drive
Suite B
Gulf Breeze, FL 32561

Boca Raton
9980 N Central Park Blvd
Suite 202
Boca Raton, FL 33428



(ustekinumab)

STELARA IV infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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

- | | |
|--|---|
| ☐ Tylenol 1000mg PO | ☐ Solu-Medrol 125mg IVP |
| ☐ Diphenhydramine 25mg PO | ☐ Solu-Cortef 100mg IVP |
| ☐ Cetirizine 10mg PO | ☐ Diphenhydramine 25mg IVP |
| _____ (other) | _____ (other) |

STELARA IV ORDERS

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE:

- | | |
|--|------------------------|
| ☐ up to 55kg- | 260mg (2 vials) |
| ☐ greater than 55kg to 85kg - | 390mg (3 vials) |
| ☐ 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 _____