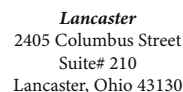


ThriveWell
INFUSION
Office: 212-803-3339 Fax : 646-768-8600



STELARA IV infusion orders *Date:* _____

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 ☐ Diphenhydramine 25mg PO ☐ Cetirizine 10mg PO ☐ Solu-Medrol 125mg IVP ☐ Solu-Cortef 100mg IVP ☐ Diphenhydramine 25mg IVP _____ (other) _____ (other) <td> 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 </td>	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:

Signature **X** _____ Date _____

Provider	Phone	Fax
----------	-------	-----