

Pensacola
41 Fairpoint Drive
Suite B
Gulf Breeze, FL 32561

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



USTEKINUMAB 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:

USTEKINUMAB IV BRANDS:	
☐ Stelara ☐ Wezlana ☐ Selarsdi ☐ Pyzchiva ☐ Otulfi ☐ Yesintek ☐ Steqeyma	

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)

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 _____