Lexington
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Bowling Green, KY 42101

ThrIVewell™ INFUSION

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

Mission Medical

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
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
_____
(other)

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
_____
(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 _____