(ustekinumab)

STELARA IV infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Crohn'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

☐ _____

STELARA INTRAVENOUS ORDERS

DOSAGE

○ up to 55kg - **260mg** (2 vials)

○ greater than 55kg to 85kg - **390mg** (3 vials)

○ greater than 85kg - **520mg** (4 vials)

PATIENT WEIGHT

_____ lbs.

_____ kg

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)

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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