Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(ustekinumab)

INFUSE ONE

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 IV 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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