Stelara Order Form
(ustekinumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ K50.0 _____ Crohn's Disease, Small Intestine
☐ K50.1 _____ Crohn's Disease, Large Intestine
☐ K50.8 _____ Crohn's Disease, Small and Large Intestine
☐ K50.9 _____ Crohn's Disease, Unspecified
Other: _____

☐ K51.8 _____ Other Ulcertaive Colitis, Chronic
☐ K51.5 _____ Left Sided - Ulcerative Colitis, Chronic
☐ K51.0 _____ Universal Ulcerative Pancolitis, Chronic
☐ K51.9 _____ Ulcerative Colitis, Unspecified

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include Negative TB within 12 months.**

PRESCRIPTION

Pre-Medications
☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
Other: _____

Lab Orders+
Required: Negative, TB, annually

+ Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider

STELARA (ustekinumab)

Loading Dose
Dilute in total volume of 250 mL of 0.9% Sodium Chloride over at least one hour via pump using a 0.2-micron filter

IV: (wt <56 kg): Infuse 260 mg (2 vials) as a single dose
IV: (wt 56 kg - 85 kg): Infuse 390 mg (3 vials) as a single dose
IV: (wt > 85 kg): Infuse 520 mg (4 vials) as a single dose

Patient Weight: _____ lbs **or** _____ kg

Post Treatment Observations: The patient is observed for 60 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____