Stelara Injection Order

(Derm use)

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ◯ L40.52 Psoriatic Arthritis
- ◯ L40.0 Psoriasis
- ◯ K50.0 Crohn's Disease
- ◯ Other _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD-10: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

STELARA ORDER

Stelara Dose: ◯ 45mg ◯ 90 mg ◯ Other _____mg **Patients weight (kg):** _____

To be administered in office only. Not for self or home injection.

Frequency: ◯ **Induction dose**: Week 0 & 4 ◯ **Maintenance dose**: Every 12 weeks

Premeds:

- ☐ Benadryl (Diphenhydramine) ◯ Oral 25mg ◯ Oral 50mg ◯ IV 50mg
- ☐ Acetaminophen (Tylenol) ◯ 325 mg ◯ 650 mg

Date of last Stelara Injection: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____