# Stelara Injection Order

*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:**
- ◯ K50.0 Crohn's Disease, unspecified
- ◯ K51.90 Ulcerative Colitis, unspecified
- ◯ Other _____

**ICD-10** _____

Patients weight: _____

Lab Date: _____

Allergies: _____

**ALSO INCLUDE...**
- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

## STELARA ORDER

**Initial Stelara Dose:**
To be administered in office only. Not for self or home injection.

Initial IV ◯ 260 mg ◯ 390 mg ◯ 520 mg

**Maintenance Stelara Dose:**
To be administered in Ambulatory Infusion Suite.

SubQ injection ◯ 45mg ◯ 90 mg ◯ Others _____

SubQ frequency ◯ Every 8 weeks ◯ Every 12 weeks

**Patients weight (kg):** _____

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

**Additional Comments:**

**Date of last Stelara Injection:** _____

## PHYSICIAN INFORMATION

**Referring Physician:** _____ **Phone:** _____

**Practice Address:** _____

**Office Contact:** _____ **Fax:** _____

**NPI/ TIN:** _____

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