Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

STELARA *(ustekinumab)* IV
Induction dose order for Crohn's disease

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis:_____

Crohn's diagnosis ICD-*10 codes*: _____, _____, _____

TB verification ***(circle one):*** **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**
☐ **COPY ATTACHED**

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive** **Negative**

LABS to be drawn: ☐ **CBC** ☐ Other: _____

Pre- Medications:	**Diphenhydramine PO or IV**	25mg or 50mg	☐Yes ☐ No
	Cetirizine PO	10mg	☐Yes ☐ No
	Acetaminophen PO	650mg	☐Yes ☐ No
	Solu-Medrol IV	_____mg	☐Yes ☐ No

* STELARA IV INDUCTION DOSE X 1 *

Stelara IV Dosage: ☐ **260mg (55kg or less)** ☐ **390mg (more than 55kg to 85 kg)**

☐ **520mg (more than 85 kg)** ☐ **Other:** _____

INFUSE STELARA IV OVER 60 MINUTES @ 250ML/HR
USE IV FILTER 0.2 MICRON FILTER

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____