Infusion Associates
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Phone: 616-954-0600 Fax: 616-954-1675

STELARA (*ustekinumab*) **Subcutaneous Injection**

***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:_____

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**

Stelara (*ustekinumab)* subcutaneous injection

Dosage: □ _____ mg

Frequency: □ Initial Dose – week 0, 4 THEN q12wks

□ q4 wks □ q6 wks □ q8 wks □ q12 wks □ Other: _____

Date of induction infusion *(if applicable):* _____

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____Office Fax Number: _____