Stelara Order

(Ustekinumab)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:
❒ Demographics ❒ Insurance Information ❒ Current CBC & CMP
❒ H & P Relevant to Diagnosis ❒ Current Medications ❒ TB Results
❒ Colonoscopy/Pathology Report

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ◯ lbs / ◯ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

TB TEST

Result: _____ Test date: _____ ❒ Copy Attached

PRE-MEDICATIONS:

Benadryl:	❒ PO	❒ IV	❒ 25mg	❒ 50mg	❒ Pre-med	❒ PRN
Acetaminophen:	❒ PO		❒ 650mg		❒ Pre-med	❒ PRN
❒ Zyrtec	❒ PO		❒ 10mg		❒ Pre-med	❒ PRN
Solu-Medrol:		❒ IV	❒ _____ mg		❒ Pre-med	❒ PRN

STELARA (USTEKINUMAB) IV DOSAGE

Date of Last Treatment, If Continuation:

Crohn's Disease

❒ 55kg or less: 260mg ❒ 56kg - 85kg or less: 390mg ❒ >85kg : 520mg

Intravenous induction dose x 1 dose over 1 hour in 250 mL normal saline