Infusion ASSOCIATES

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

Stelara IV Infusion

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

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

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

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

ICD-10 : _____, _____, _____

TB verification: ☐ **TB skin test** ☐ **TB spot/Quantiferon blood test** ☐ **Chest X-ray**

Result Date: _____/_____/_____ **Result:** ☐ **Positive** ☐**Negative**

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

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

Stelara (ustekinumab) IV Dose:

☐ 260 mg *(55kg or less)*
☐ 390 mg *(55-85kg)*
☐ 520mg *(more than 85 kg)*
☐ Other:_____

Frequency:

☐ Once
☐ Every _____ weeks

Printed Provider Name: _____

Provider Signature: _____

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