Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Stelara (ustekinumab) ADULT DOSING

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

* * If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required * *

DIAGNOSIS AND ICD-10 CODE	
☐ Moderate to Severe Ulcerative Colitis	K51.90
☐ Moderate to Severe Crohn's Disease	K50.90
☐ Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ Negative QuantiFERON Gold TB Test or Skin PPD	☐ HBV Panel results
☐ Patient currently receiving same therapy at _____ Last dose: _____	
List Tried & Failed Therapies, including duration of treatment	
1)	3)
2)	4)

MEDICATION ORDERS- ADULT DOSING**	
Initial Dosing (for Gastroenterology)	☐ Stelara (≤55kg) 260mg infuse IV over 1 hour x 1 dose
	☐ Stelara (55kg to 85kg) 390mg infuse IV over 1 hour x 1 dose
	☐ Stelara (>85kg) 520mg infuse IV over 1 hour x 1 dose
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in
Duration: x 1 dose	

**Infusion Solutions NO longer accepts orders for Subcutaneous Injections for Stelara
due to the product being on the Self-Administered Drug Exclusion List (SAD List).
Infusion Solutions team will notify the Ordering Provider's office when the IV initial dosing has been completed.
It will be the Ordering Provider's responsibility to work with the patient's insurance carriers to obtain
the Subcutaneous Injections for self-administer to continue therapy.

OPTIONAL PREMEDICATIONS and LAB ORDERS
☐ Acetaminophen 650mg PO prior to infusion and/or injection
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion and/or injection
☐ Methylprednisolone 40mg slow IVP prior to infusion
☐ Other PreMed or Lab Order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.