CURBSIDE INFUSION SERVICES

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Scheduling@curbsideinfusion.com Ext. 0
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STELARA IV (ustekinumab) infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Crohn's Disease

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Quzyttir 10mg IVSP over 1-2 min
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____

STELARA IV ORDERS

DOSAGE

◉ up to 55kg - **260mg** (2 vials)
○ greater than 55kg to 85kg - **390mg** (3 vials)
○ greater than 85kg - **520mg** (4 vials)

PATIENT WEIGHT

_____ lbs.
_____ kg

FREQUENCY

○ initial infusion followed by SQ injections self-administered
(follow-up maintenance injections to be coordinated by a specialty pharmacy and are not part of this order)

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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