sage infusion

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Phone: 813.775.9997 | Fax: 813.775.9997
Email: intake@sageinfusion.com | Online: www.sageinfusion.com

(ustekinumab)

STELARA IV 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
☐ _____

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____

STELARA INTRAVENOUS 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

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____