



STELARA ORDER GI	□ New Start □ Maint	enance: Last Dose Giv	ven
Referring Office:	Contact Name:		Date:
Direct Phone for Contact:		Fax:	
Patient Name:		DOB:	
Allergies □ NKDA □ Allergies:			
		Height:	
Weight:			
Indication: ☐ K50.90 Moderate to severe Crohn's disea ☐ K51.90 Ulcerative Colitis ☐ Other			
DRUG:			
☐ Initial IV Dose☐ Up to 55kg 260 mg (2 vials)			
☐ Greater than 55 kg to 85 kg 390 mg (3 v	vials)		
☐ Greater than 85 kg 520 mg (4 vials)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
☐ Subsequent doses:			
☐ Patient will self-inject subsequent doses			
$\ \square$ 90mg SQ 8 weeks after IV dose then ev	ery 8 weeks		
□ Other			
PREMEDICATION ORDERS: not required by PI			
☐ Acetaminophen po: ☐ 1000mg ☐ 500mg 3	•		
☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO			
☐ Solu-Medrol: ☐ 62.5mg IVP ☐ 100mg IVP	Other 30 min pri	or to infusion.	
□ Other			

Prescriber Name:	Title:	
NPI:	DEA:	
Prescriber Signature:	Date of Order:	
Referrals will not be processed until we receive <u>ALL</u> the fo ☐ Face Sheet / Patient Demographics	llowing:	
☐ Face sheet / Patient Demographics ☐ Insurance card(s) – copy of front & back		
 ☐ Last 2 clinic notes pertaining to referring diagnosis (includutcomes) Most Recent Labs (within last 4-8 weeks) – Requ 	• • • • • • • • • • • • • • • • • • • •	