Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

STELARA INJECTION ORDER
(Ustekinumab)

Please fax a copy of patient's demographics, insurance information, current lab results including TB results, H&P relevant to diagnosis, and current medications.

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ICD-10: _____

TB test result & date: _____

Stelara Injection (Ustekinumab) 45 mg/0.5 mL

Psoriatic Arthritis or Plaque Psoriasis

Loading dose at weeks 0 and 4, then every 12 weeks, subcutaneous injection.

☐ **45 mg** **OR** ☐ **90 mg**

Crohn's Disease

Maintenance Dose Only:

☐ **90 mg subcutaneous injection 8 weeks after initial IV dose, then every 8 weeks**

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office phone number: _____ Office Fax:_____

Office address: _____Contact person: _____

Revised 10/17/17