

**Fax form to:**

Billings - 406.206.0105      Colorado Springs - 719.623.0085  
 Great Falls - 406.794.0555      Grand Junction - 970.404.8100  
 Boise - 208.545.3214

**INFUSION ORDERS STELARA**

**Patient's Information**

Date of Referral

First Name

Last Name

M.I.

Date of Birth

Address



City

State

ZIP Code

Phone

WT (kg)

HT (in)

Diagnosis

Allergies

**\*Please fax all recent labs including TB date/result as well and any pertinent labs required for this drug.**

\*ICD 10 CODE

**\*Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

**STELARA DOSING**

- Initial Dosing
- A single intravenous infusion using weight-based dosing: Use only an infusion set with an in-line, sterile, non-pyrogenic, low protein-binding-filter (pore size 0,2 micrometer)
- Up to 55kg: 260mg
- 55kg to 85kg: 390mg
- Greater than 85kg: 520mg
- Maintenance injection of 90mg  
 every week refills

Premedications

Prescribing Provider

Address



City

State

ZIP Code

Provider  
Signature

Date

Provider Phone

Provider Fax