TALIS HEALTHCARE

Return Completed Form To:
888.898.9113

INFUSION ORDER – STELARA (ustekinumab)

Patient First Name: _____ Patient Last Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Referral Date: _____ Weight (kg): _____ Height (in): _____

Diagnosis: _____

Allergies: _____ TB Test Results: _____

STELARA DOSING

- ☐ Initial Dosing
- ☐ Up to 55kg: 260mg
- ☐ 55kg to 85kg: 390mg
- ☐ Greater than 85kg: 520mg
- ☐ TB Test Results: _____

- ☐ 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)
- ☐ Maintenance Dosing: 90mg subcutaneously every 8 weeks after initial intravenous dose and then 8 weeks thereafter

Prescribing Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

ICD 10 CODE: _____

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.