MIC | METRO INFUSION CENTER

Phone: 877.448.3627

Fax completed form to:
866-507-1164

INFUSION ORDERS — STELARA

Date of referral: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code:_____

Phone: _____ WT (kg): _____ HT: _____(in)

Diagnosis:_____

Allergies: _____

***ICD 10 CODE:** _____

***Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form.**

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 Dosing: 90mg subcutaneously every 8 weeks after initial intravenous dose and then 8 weeks thereafter
- ☐ TB Test Results: _____

Prescribing Physician: _____

Address: _____

Physician Signature: _____

Date:_____

Physician Phone: _____ Fax: _____