Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

Stelara (Ustekinumab)
Orders

Required Information:

- ☐ Signed order from prescribing provider
- ☐ Patient demographics including insurance information
- ☐ Supporting clinical documentation: Visit notes, diagnostic results
- ☐ Required Labs: TB & Hep B screening

Primary Diagnosis:

- ☐ Crohn's Disease (ICD-10 :_____)
- ☐ Ulcerative Colitis (ICD-10:_____)
- ☐ Psoriatic Arthritis (ICD-10 :_____)
- ☐ Plaque Psoriasis (ICD-10 :_____)

STELARA ORDERS

Induction IV dose:
- ☐ <55kg: Stelara 260mg IV x 1 dose
- ☐ 55kg to 85kg: Stelara 390mg IV x 1 dose
- ☐ >85kg: Stelara 520mg IV x 1 dose

Mainentance IV dose:
- ☐ >85kg: Stelara 520mg IV x 1 dose
- ☐ Other: Stelara _____mg IV x 1 dose

SubQ dose:
- ☐ 90mg SQ 8 weeks after the initial infusion & every 8 weeks thereafter
- ☐ 45mg SQ on week 0, 4, then every 12 weeks
- ☐ 90mg SQ on week 0, 4, then every 12 weeks
- ☐ Other:_____

Administered per manufacturer guidelines

Date of Last Stelara: _____

PRE-MEDICATIONS

- ☐ PO Tylenol _____mg
- ☐ PO Cetirizine _____mg
- ☐ IV Solu-medrol _____mg
- ☐ PO Loratadine _____mg
- ☐ PO ☐ IV Diphenhydramine _____mg
- ☐ PO ☐ IV Other:_____ _____mg

LABS

- ☐ CBC
- ☐ CMP
- ☐ CRP
- ☐ ESR
- ☐ TB Quantiferon Gold
- ☐ Hep B Core/Surface AG
- ☐ Uric Acid
- ☐ Other:_____
- ☐ Other:_____

Frequency:
- ☐ Every Visit
- ☐ Every Other Visit
- ☐ One time only
- ☐ Other:_____

CPL Acct #:_____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

_____

_____

_____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**