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STELARA (USTEKINUMAB) MEDICATION ORDERS

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
- TB documentation
- TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. Yearly TB Screening (*Optional*)

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis: Plaque Psoriasis (ICD-10: _____) Psoriatic Arthritis (ICD-10: _____)

Pt. Weight _____ kg

Stelara: Patients weighing < 100kg, 45mg subQ initially and 4 weeks later, followed by 45mg every 12 weeks
 Patients weighing > 100kg, 90mg subQ initially and 4 weeks later, followed by 90mg every 12 weeks
 Other: _____

Diagnosis: Crohn's (ICD-10: _____) Ulcerative Colitis (ICD-10: _____)

Pt. Weight _____ kg

Stelara Initial Infusion: <55kg 260mg IV over 1 hour x 1 dose
 55kg to 85kg 390 mg IV over 1 hour x 1 dose

Stelara Maintenance: >85kg 520 mg IV over 1 hour x 1 dose
 90 mg SQ 8 weeks after initial infusion and then refill every 8 weeks for 1 year for a total of 6 refills

Additional Instructions:

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