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: 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: _____)

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: