STELARA
(ustekinumab)

FAX to +1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Most Recent Labs
- Neg TB Results
- History & Physical
- Medication List
- Tried/Failed Therapies

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications (CD)
☐ K50.019 Crohn's disease of small intestine with unsp comp (CD)
☐ K50.10 Crohn's disease of large intestine without complications (CD)
☐ K50.90 Crohn's disease, unspecified, without complications (CD)
☐ K51.00 Ulcerative (chronic) pancolitis without complications (UC)
☐ K51.90 Ulcerative colitis, unspecified, w/o complications (UC)

☐ L40.5 Psoriatic Arthritis (PsA)
☐ L40.9 Plaque Psoriasis (Ps)

☐ Other:________________________________

PRE-MEDICATIONS

*Per infusion clinic protocol: No recommended standard pre-meds for Stelara
☐ Provider Prescribed: ________________________________

PRIMARY MEDICATION ORDER

Ulcerative Colitis (UC) – or – Crohn's Disease (CD)

Induction Doses (to be administered in infusion clinic):
☐ Stelara 260mg <55kg IV once
☐ Stelara 390mg 55-85kg IV once
☐ Stelara 520mg >85kg IV once

Maintenance Doses:
☐ Infusion clinic will coordinate with SP for self-administration or administration in-clinic as payor dictates: Stelara 90mg SubQ every 8 weeks after induction dose.
☐ Provider's office will coordinate initial maintenance dose from SP.

Plaque Psoriasis (Ps) – or – Psoriatic Arthritis (PsA)

☐ Stelara 45mg≤ 100kg / 90mg > 100kg SubQ at weeks 0, 4, and every 12 weeks thereafter.
*Infusion clinic will coordinate initial dose from Specialty Pharmacy

☐ Other:________________________________

First Dose: ☐ Y ☐ N   Refill x12 months unless otherwise noted:________________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialists.org com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

________________________________ ________________
Provider Signature   Date