SPECIALTY INFUSION CENTERS

STELARA ORDER FORM
(Ustekinumab)

FAX TO: 800-540-1852

PATIENT INFORMATION

Patient Name: ______________________ DOB: ______________ Phone: ______________ Sex: M / F

Ht: ____ WT: ____ lbs / kg Primary Language: ______________ Allergies: ______________

Patient Preferred Location: ☐ Staten Island ☐ West Harrison ☐ Manhattan ☐ New Paltz ☐ Bronx ☐ Syosset ☐ Port Jefferson ☐ Millburn ☐ Brooklyn Heights ☐ Paramus

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ L40. ______
☐ K50. ______
☐ K51. ______

Prescribing Information

90 mg dose only suggested for patients > 100 kg Psoriasis or Psoriatic Arthritis w/ co-existent moderate-to-server Plaque Psoriasis. Pre-meds are not suggested for SubQ dosage.

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: Include Negative TB within 12 months.

PRESCRIPTION

Pre-Medications

☐ Tylenol 650mg PO ☐ Benadryl 25mg IVP ☐ Pepcid 20mg IVP
☐ Zyrtec 10mg PO ☐ Benadryl 50mg PO ☐ Solu-medrol 125mg IVP
☐ Claritin 10mg PO ☐ Benadryl 50mg IVP ☐ Solu-medrol 250mg IVP
☐ Benadryl 25mg PO ☐ Pepcid 20mg PO ☐ Solu-medrol 500mg IVP

Other: ______________

Pre Labs:

☐ CBC ☐ Iron Panel
☐ CMP ☐ Vitamin D
☐ CRP ☐ Other ______________
☐ ESR

Stelara (ustekinumab)

Loading Dose:

☐ IV: Infuse ______mg at week 0 then continue with maintenance dose 8 weeks later
☐ SubQ: Inject 90 mg at weeks 0 and 4

Maintenance Dose: (SELECT ONE)

☐ SubQ: Inject 45 mg every ___weeks
☐ SubQ: Inject 90 mg every ___weeks

PRESCRIBER INFORMATION

Prescriber Name: ______________________ Signature:

Supervising Provider (if applicable) ______________________

Date: __________ NPI#: ______________ Specialty: ______________

Practice Name: ______________________________ (If Applicable)

Address: ______________ City: __________ State: ______ Zip: ______

Contact Name: ______________ Phone: ________ Fax: ________ Email: ______________