Local Infusion

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STELARA (USTEKINUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________ DOB: __________

Mobile Number: __________ Allergies: ______________________

DIAGNOSIS (Provider must specify)

❑ Psoriatic Arthritis, ICD 10: L40.__________ ❑ Crohn's Disease, ICD 10: K50.__________

❑ Psoriasis, ICD 10: L40.__________ ❑ Ulcerative Colitis, ICD 10: K51.__________

❑ Other: ______________________

PROVIDER INFORMATION

Provider Name (print name): ______________________ Provider NPI:__________

Signature: ______________________ Date: __________

Contact Name: ______________ Phone: __________ Fax: __________

Email Address: ______________________

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO ❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: ______________ Dose: __________ Route: __________

MEDICATION

MEDICATION	DOSE / ROUTE	FREQUENCY
Stelara	❑ 45 mg / Subcutaneous Inj. ❑ 90 mg / Subcutaneous Inj. ❑ 260 mg / IV ❑ 390 mg / IV ❑ 520 mg / IV	❑ x 1 dose ❑ Week 0, 4, then every 12 weeks ❑ Every 12 weeks_

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): __________

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ NH: 603.217.5371 ❑ ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: __________