

# USTEKINUMAB (AND BIOSIMILAR) ORDER FORM

- Selardsi (ustekinumab-aekn)     Yesintek (ustekinumab-kfce)     Otulfi (ustekinumab-aauz)  
 Steqeyma (ustekinumab-stba)     Stelara (ustekinumab)     Wezlana (ustekinumab-auub)

Will substitute for biosimilar or reference product based on insurance and availability

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_  
 Patient has known difficult venous access. Comments: \_\_\_\_\_

## 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
Ustekinumab	<input type="checkbox"/> 260 mg <input type="checkbox"/> 390 mg <input type="checkbox"/> 520 mg	IV	x 1 dose
	<input type="checkbox"/> 45 mg <input type="checkbox"/> 90 mg	Subcutaneous inj.	<input type="checkbox"/> 8 weeks after initial IV dose then every 8 weeks <input type="checkbox"/> Every 8 weeks

x1 IV infusion needs to be completed prior to SubQ injections.

- Please check this box if you DO NOT want Local Infusion to complete insurance portion for SubQ.

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS

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

**FAX NUMBERS:**

- CT: 203.433.0621  
 FL: 904.877.9270

- MA: 413.296.8482  
 MD: 240.224.8607  
 ME: 207.407.7272

- NC: 919.984.8698  
 NH: 603.217.5371  
 NJ: 201.581.4521

- NY: 631.250.6020  
 OH: 937.871.4594  
 PA: 610.273.5998

- SC: 864.973.6279  
 VA: 703.202.0499