

STELARA (USTEKINUMAB) ORDER FORM

GASTROENTEROLOGY

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Allergies: _____

DIAGNOSIS (Provider must specify)

Crohn's Disease, ICD 10: K50. _____ 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 | <input type="checkbox"/> 260 mg (<55kg) <input type="checkbox"/> 390 mg (55–85kg) <input type="checkbox"/> 520 mg (>85kg) | <input type="checkbox"/> IV | <input type="checkbox"/> x 1 dose |
| | Then <input type="checkbox"/> 90 mg | <input type="checkbox"/> 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