Local Infusion

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STELARA (USTEKINUMAB) ORDER FORM

RHEUMATOLOGY

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Allergies: _____

DIAGNOSIS (Provider must specify)

❑ Psoriatic Arthritis, ICD 10: L40._____ ❑ Psoriasis, ICD 10: L40._____

❑ 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.	❑ 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: ❒ CT: 203.433.0621 ❒ MD: 240.224.8607 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371
❒ NJ: 201.581.4521 ❒ VA: 703.202.0499

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