Stelara (Ustekinumab) Referral Form

REQUIRED INFORMATION

This signed order form from the provider
Patient demographics and insurance information
Clinical/Progress Notes, Labs (including TB Test), and Tests supporting primary diagnosis (ICD-10 below)
Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	

Diagnosis:
Plaque Psoriasis (ICD-10 _____) **Psoriatic Arthritis (ICD-10 _____)** **Hidradenitis Suppurativa (ICD-10 _____)**

Stelara Dose: Patients weighing ≤ 100 kg: 45 mg/0.5 mL subq at weeks 0 and 4, then every 12 weeks thereafter

Patients weighing > 100 kg: 90 mg/mL subq at weeks 0 and 4, then every 12 weeks thereafter

Refill: PRN x 1 year OR _____ times

Diagnosis:
Crohn's Disease (ICD-10 _____) **Ulcerative Colitis (ICD-10 _____)** **Other (ICD-10 _____)**

Stelara Initial Infusion Dose: Patients weighing < 55 kg: 260 mg/250 mL IV over 1 hour x 1 dose

Patients weighing 55 kg – 85 kg: 390 mg/250 mL IV over 1 hour x 1 dose

Patients weighing > 85 kg: 520 mg/250 mL IV over 1 hour x 1 dose

Stelara Maintenance Dose: 90 mg/mL subcutaneous injection every _____ weeks

Other: _____

Refill: PRN x 1 year OR _____ times

Pre-Medication Orders (optional):

Acetaminophen 650 mg PO OR Acetaminophen 1000 mg PO

Diphenhydramine 25 mg PO OR Cetirizine 10 mg PO

Other: _____

Required routine labs to be drawn by Infusion Center Referring Physician

Labs: _____ Frequency: _____

Supply Orders: Pharmacy to provide all supplies needed to complete therapy as prescribed

May use Pharmacy's flush and catheter maintenance protocol

Nursing Orders: Pharmacy to provide nursing services, including vascular access, administration, and line care

May use Pharmacy's anaphylaxis protocol

Additional Instructions:

Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		