

STELARA® (USTEKINUMAB) PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128

☐ **NEW PATIENT** OR
☐ **CHANGE ORDER:** ☐ Drug Change ☐ Dose Change ☐ Interval Change

Patient Name:	Date of Birth:
Phone:	Gender:
Address:	
Allergies:	
Height: <input type="checkbox"/> in <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg

CLINICAL INFORMATION

Primary Diagnosis Description:	ICD-10 Code:
Is this the first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No – date of next dose due: _____	

Treatments – Tried and Failed:

TB Status: ☐ PPD (negative) – date: _____ ☐ Active TB
☐ Last chest X-ray – date: _____ ☐ Other: _____
☐ Past positive TB infection, course taken: _____

PRESCRIPTION

Stelara® (Ustekinumab) refill as directed x 1 year
 Initial Dose: ☐ IV: Infuse over at least 1 hour once (check one): ☐ 260mg (up to 55kg) ☐ 390mg (>55kg to 85kg) ☐ 520mg (>85kg)
☐ SUBQ: Nurse to inject _____ mg SUBQ initially and repeat 4 weeks later.
 Maintenance Dose: ☐ Nurse to inject _____ mg SUBQ every _____ weeks.
 Next Dose Due Date: _____

ANCILLARY ORDERS

Pre-Medication Orders:
☐ Acetaminophen 650mg PO 30 minutes before infusion.
☐ Diphenhydramine 25mg PO/IV 30 minutes before infusion.
☐ Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.
☐ Other: _____

PRN Hypersensitivity Meds:

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>30kg)

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

PRESCRIBER INFORMATION

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State, Zip:	Office Contact:	

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