Fountains Infusion Center

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STELARA (USTEKINUMAB) MEDICATION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
- ☐ TB documentation
- ☐ **TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis: ☐ Plaque Psoriasis (ICD-10: __________) ☐ Psoriatic Arthritis (ICD-10: __________)

Pt. Weight ____________ kg

Stelara:
- ☐ Patients weighing < 100kg, 45mg subQ initially and 4 weeks later, followed by 45mg every 12 weeks
- ☐ Patients weighing > 100kg, 90mg subQ initially and 4 weeks later, followed by 90mg every 12 weeks
- ☐ Other:____

Diagnosis: ☐ Crohn's (ICD-10: __________)

Pt. Weight ____________ kg

Stelara Initial Infusion:
- ☐ <55kg 260mg IV over 1 hour x 1 dose
- ☐ 55kg to 85kg 390 mg IV over 1 hour x 1 dose

Stelara Maintenance:
- ☐ >85kg 520 mg IV over 1 hour x 1 dose
- ☐ 90 mg SQ 8 weeks after initial infusion and then refill every 8 weeks for 1 year for a total of 6 refills

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	