PRESCRIPTION ORDER FORM

STELARA
(ustekinumab)

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Dem • Most Recent Labs • Med List • HBV/HCV • Tried/Failed Therapies • Neg TB Results

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications (CD)
☐ K50.019 Crohn's disease of small intestine with unsp comp (CD)
☐ K50.10 Crohn's disease of large intestine without complications (CD)
☐ K50.90 Crohn's disease, unspecified, without complications (CD)
☐ K51.00 Ulcerative (chronic) pancolitis without complications (UC)
☐ K51.90 Ulcerative colitis, unspecified, w/o complications (UC)
☐ L40.5 Psoriatic Arthritis (PsA)
☐ L40.9 Plaque Psoriasis (Ps)
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐ Solu-Medrol 40mg IVP ☐ Solu-Cortef 125mg IVP ☐ Tylenol 650mg PO ☐ Other: _____

PRIMARY MEDICATION ORDER

Ulcerative Colitis (UC) – or – Crohn's Disease (CD)

Induction Doses (to be administered in infusion clinic):
☐ Stelara 260mg <55kg IV once infuse over 60 mins
☐ Stelara 390mg 55-85kg IV once infuse over 60 mins
☐ Stelara 520mg >85kg IV once infuse over 60 mins

Maintenance Doses:
☐ Infusion clinic will coordinate with SP for self-administration or administration in-clinic as payor dictates: Stelara 90mg SubQ every 8 weeks after induction dose.
☐ Provider's office will coordinate initial maintenance dose from SP.

Plaque Psoriasis (Ps) – or – Psoriatic Arthritis (PsA)

☐ Stelara 45mg ≤ 100kg / 90mg > 100kg SubQ at weeks 0, 4, and every 12 weeks thereafter.
*Infusion clinic will coordinate initial dose from Specialty Pharmacy

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date