

Stelera (Ustekinumab) Infusion/Injection Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code): _____

Other: _____

NKDA Allergies: _____

New Therapy Order Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

- Acetaminophen _____mg by PO
- Cetirizine _____mg by PO
- Diphenhydramine _____mg by PO/ IVP
- Solu-Medrol _____mg by PO/ IVP
- Solu-Cortef _____mg by PO/ IVP
- Other: _____

Required Documentation:

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Hepatitis B status and date
- CBC, CMP, Quantiferon, ESR, CRP lab results
- Most recent colonoscopy (within one year)
- Other: _____

Stelera is a weight based drug:

Patient Height (cm): _____ Patient Weight (kg): _____

Stelera Medication Order (Please Choose Applicable):

- Initial Induction Infusion:
 - Dosage (choose one)
 - 260 mg (2 vials) (<55 kg)
 - 390 mg (3 vials) (55 kg - 85 kg)
 - 520 mg (4 vials) (>85 kg)
- Initial Induction Infusion followed by Maintenance Subcutaneous Injections:
 - 90 mg 8 weeks after infusion, and every 8 weeks thereafter
- Maintenance Subcutaneous Injections Only
 - 90 mg every 8 weeks

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400