vitalcare INFUSION SERVICES of SIOUX FALLS

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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)*

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|---|---|
| **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:** | |