SPECIALTY INFUSION CENTER
An Access Infusion Care Company

STELARA (USTEKINUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD 10 CODE

☐ Moderate to Severe Plaque Psoriasis ICD-10 Code: _____

☐ Active Psoriatic Arthritis ICD-10 Code: _____

☐ Moderate to Severe Crohn's Disease ICD-10 Code: _____

☐ Moderate to Severe Ulcerative Colitis ICD-10 Code: _____

☐ Other: ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ TB Test Results

☐ H&P and Clinical/Progress notes supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

☐ Hepatitis B Test Results: HBsAg & total HepB Core antibody

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

Plaque Psoriasis	☐ Stelara 45 mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight ≤ 100kg) ☐ Stelara 90 mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight > 100kg)
Psoriatic Arthritis	☐ Stelara 45 mg SubQ at Week 0, 4, then every 12 weeks thereafter ☐ Other: Stelara _____ mg SubQ every_____weeks
Crohn's Disease Ulcerative Colitis	Initial IV dose (choose one): ☐ Stelara 260 mg IV x1 (Weight <55kg) ☐ Stelara 390 mg IV x1 (Weight 55-85kg) ☐ Stelara 520 mg IV x1 (Weight >85kg) Maintenance Dosing (will start 8 weeks after IV dose, when applicable): ☐ Stelara 90 mg SubQ every 8 weeks

Refills*: ☐ X 6 months ☐ X 1 Year Other: _____

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol

Other: _____

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

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REV: 6/2025

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