

STELARA®(USTEKINUMAB) PRESCRIBER ORDER FORM		
FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to (757) 466-1128		
<input type="checkbox"/> NEW PATIENT OR <input type="checkbox"/> CHANGE ORDER: Drug Change Dose Change Interval Change		
Patient Name:		Date of Birth:
Address:		
Allergies:		
Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg
CLINICAL INFORMATION		
Primary Diagnosis Description:		ICD-10 Code:
Is this the first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No – date of next dose due: _____		
Treatments – Tried and Failed:		
TB Status: <input type="checkbox"/> PPD (negative) – date: <input type="checkbox"/> Active TB <input type="checkbox"/> Unknown <input type="checkbox"/> Last chest X-ray – date: <input type="checkbox"/> Other: _____ <input type="checkbox"/> Past positive TB infection, course taken: _____		
STELARA® (Ustekinumab) PRESCRIPTION		
Stelara® (Ustekinumab) refill as directed x 1 year		
Initial Dose: <input type="checkbox"/> IV: Infuse over at least 1 hour once (check one): <input type="checkbox"/> 260mg (up to 55kg) <input type="checkbox"/> 390mg (>55kg to 85kg) <input type="checkbox"/> 520mg (>85kg) <input type="checkbox"/> SUBQ: Nurse to inject _____ mg SUBQ initially and repeat 4 weeks later.		
Maintenance Dose: <input type="checkbox"/> Nurse to inject _____ mg SUBQ every _____ weeks.		
Next Dose Due Date: _____		
ANCILLARY ORDERS		
Pre - Medication Orders:		
<input type="checkbox"/> Acetaminophen 650mg PO 30 minutes before infusion. <input type="checkbox"/> Diphenhydramine 25mg PO/IV 30 minutes before infusion <input type="checkbox"/> Methylprednisolone Succinate 125mg IV push 20 minutes before infusion. <input type="checkbox"/> Other: _____		
PRN Hypersensitivity Meds:		
<ul style="list-style-type: none"> • Epinephrine 0.3mg • Solu-Cortef 100mg • Solu-Medrol 125mg • Diphenhydramine 25-50mg • NS 500 ML (>30kg) 		
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>		
Prescriber Signature:		Date:
PRESCRIBER INFORMATION		
Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:
<small>CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. IMPORTANT WARNING: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of the information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.</small>		